Exhibit A
Scope of Work – Attachment II
Operations

The use of headings of titles throughout this exhibit is for convenience only and shall not be used to interpret or govern the meaning of any specific term, function, or activity.

1.0 OPERATIONS REQUIREMENTS

The Operations Phase constitutes the operations work activities required of the Contractor in this contract. The activities described in this chapter shall commence with the startup of Treatment Authorization Request (TAR) processing which is scheduled to take place four (4) months and fifteen (15) days after contract effective date, which coincides with Takeover (See Exhibit A, Attachment I, Takeover) except for Security and Confidentiality operations requirements, which shall begin on contract effective date. The Contractor shall operate and maintain the California Dental Medicaid Management Information System (CD-MMIS). This system includes numerous processing requirements, which shall be performed by the Contractor and are detailed throughout the remainder of this Chapter.

At the start of the contract, the Contractor will receive the latest version of the CD-MMIS software. The Department will not freeze the operational system during this procurement or during the Takeover period, and will continue to direct program policy changes through the Dental Operating Instruction Letter (DOIL) process. DOILs are used to instruct the Contractor regarding the policy changes and language to be used by the Contractor in the issuance of provider bulletins or manual updates. The Department will also continue to direct system changes through either System Development Notices (SDNs), Miscellaneous Change Documents (MCDs) or Change Orders. SDNs or Change Orders that are not currently documented in the design documentation and those that the Department anticipates will be installed prior to the contract effective date will be located in the data library. SDNs will continue to be issued with system changes to be installed into the operational CD-MMIS by the incumbent. The Department will issue Change Orders to the Contractor for those SDNs that would normally result in a Change Order to the Contractor for its operations price. Any system changes installed by the incumbent after contract effective date will be provided to the Contractor for completion of system installation. The Contractor shall be responsible for testing these changes before installation.

1.1 SPECIAL CONSIDERATION

The Department reserves the right to require the Contractor to contract with a Department-approved Independent Verification and Validation (IV&V) contractor for the development and/or implementation of large/complex system changes. The IV&V shall be reimbursed according to the Cost Reimbursement provisions of the contract.

1.2 DEFINITION OF CD-MMIS

The acronym "CD-MMIS" stands for California Dental Medicaid Management Information System. CD-MMIS has been certified by the Centers for Medicare and Medicaid Services (CMS) as meeting the requirements of the Social Security Act, Title XIX, providing federal matching funds to states implementing a single comprehensive dental care program.

The CD-MMIS consists of the processing of dental claims/TARs/NOAs and related documents, and the operation of related systems that are currently operated by the incumbent for the Department including dental services provided under the Medi-Cal Dental Program, Genetically Handicapped Persons' Program (GHPP), Healthy Families (HF), the Children's Treatment Program (CTP), Child Health and Disability Prevention (CHDP) Gateway, California Children's Services (CCS), and the County Medical Service Program (CMSP). Throughout this chapter, the term "claim" is used to refer to claims as well as to Notices of Authorization (NOAs) returned for processing as claims.

The Department expects that throughout the life of this contract, other TAR and claim processing or operational systems will be transferred and/or otherwise developed and added.

1.2.1 DEFINITION OF CD-MMIS CLAIMS PROCESSING SYSTEM

1.2.1.1 COMPONENTS

1) Computer programs (including necessary COPYLIB and ++INCLUDE members) and system files necessary to assume operation of CD-MMIS;

2) Manual procedures maintained in the OMCP Data Library;

3) Job Control Language (JCL) currently used by the incumbent, which will serve as the basis for the Contractor to set up its own JCL to operate CD-MMIS;

4) Change Orders and DOILs;

5) Implemented SDNs and MCDs;

6) Department-owned Hardware; and

7) Other Department owned and licensed software.

1.2.1.2 CHANGES

Changes are expected to the above components between the time the RFP is issued and when the Contractor assumes TAR processing operations. For example, new DOILs will be available in the OMCP Data Library as they are issued. Manual procedure changes will be reflected in updates to manuals maintained in the OMCP Data Library.

The Department will continue to develop and implement SDNs and MCDs under the current contract throughout the phases of this procurement process. An updated list of all active SDNs, including those SDNs in process and those anticipated to be installed prior to the Operations Period, is available in the OMCP Data Library.

1.2.1.3 SUBSYSTEMS

CD-MMIS is divided into the following inter-related subsystems:

1) Recipient Subsystem;

2) Provider Relations Subsystem;

3) Reference File Subsystem;

4) Claims Processing Subsystem;

5) Management and Administrative Reporting Subsystem (MARS);

6) Surveillance and Utilization Review Subsystem (SURS); and

7) Non-Mainframe Subsystem.

1.2.1.4 SYSTEM DESIGN DOCUMENTATION

Contractor requirements for each of these subsystems are outlined in subsequent sections of Exhibit A, Attachment II, Operations. Complete descriptions are included in the system design documentation. System design documentation includes the automated system descriptions as defined in the computer programs and the various subsystem, general, and conceptual designs, as well as the various manual process descriptions in the procedure manuals. Copies of the system design documentation are maintained in the OMCP Data Library.

1.2.1.5 RESOLVING INCONSISTENCIES

The documentation and the automated systems are subject to change as updates are made. There may be inconsistencies among the computer programs and procedure manuals included in CD-MMIS, the supporting design documentation, and the RFP. The following hierarchy, in the order specified, shall be observed in resolving inconsistencies:

1) DOILS;

2) SDNs;

3) MCDs;

4) Change Orders;

5) RFP requirements;

6) CD-MMIS computer programs;

7) CD-MMIS procedure manuals; and

8) System design documentation.

1.2.1.6 INPUTS

CD-MMIS has many manual and automated interfaces with state agencies, providers, and other entities, as well as many distinctive features. The major interfaces (i.e., inputs and outputs) and distinctive features include:

1) Claims from providers (claims are submitted on paper, magnetic tape, computer diskette, or via electronic transmission);

2) Eligibility files and inquiries from the Department, providers, and other entities;

3) Medi-Cal and other program policy updates from the Department;

4) Change Orders, SDNs, MCDs, and DOILs from the Department;

5) Claim Detail Report (CDR) requests from the Department and other authorized users;

6) Surveillance Utilization Review System (SURS) parameters from the Department;

7) Treatment Authorization Requests (TARs) from providers;

8) Radiographs supporting claims/TARs from providers;

9) Share-of-Cost form (MC177) facsimiles;

10) Fair Hearing Requests/Decisions;

11) Managed Care Plan encounter data;

12) Licensing information from the Department of Consumer Affairs; and

13) Supporting documentation from providers.

1.2.1.7 OUTPUTS

1) Provider manuals, bulletins, claim forms, NOAs and other documents distributed to providers;

2) Files/tables and audit data on hard copy, microfilm and/or electronic media;

3) Resubmission Turnaround Documents (RTDs) and claim inquiry responses;

4) Microfilmed and electronic copies of claims;

5) Checkwrite summary data on hard copy and electronic media;

6) Balancing Reports;

7) Paid claims tape to the Department;

8) Management reports;

9) SURS reports;

10) CDRs;

11) Checks and Explanation of Benefits (EOBs) to provider;

12) Reviewed radiographs returned to providers;

13) Fair Hearing transmittal memoranda;

14) MC177 facsimiles;

15) Various Financial Reports;

16) Manual (MN) Reports; and

17) Beneficiary Treatment Authorization Requests Notification Letters.

1.2.1.8 DISTINCTIVE FEATURES

1) Claims may be submitted on paper or electronic media;

2) Claims and other paper inputs are currently microfilmed prior to data entry (radiographs excluded);

3) Claims and other paper inputs are currently microfilmed after data input preparation and processed through the Optical Character Recognition (OCR) scanners;

4) All electronic media claims and digitally submitted claim images are stored on Computer Media Claims Computer Output to Laser Disc (CMC COLD), and the paper claim and other paper inputs are stored on microfilm;

5) The Contractor performs many major interfaces such as clinical screening of beneficiaries, dental fair hearing activities and Provider Enrollment/Certification services; and

6) Manual processing is heavily dependent on professional and paraprofessional review of claims/TARs/NOAs/CIFs/RTDs and supporting documentation.

2.0 RECIPIENT SUBSYSTEM

2.1 OVERVIEW

The Recipient Subsystem provides centralized control of eligibility data for all Medi-Cal, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), County Medical Services Program (CMSP), Children's Treatment Program (CTP), Child Health and Disability Prevention (CHDP) Gateway, and Healthy Families (HF) beneficiaries. The Recipient Subsystem receives information maintained exclusively by the Department to identify those persons who are eligible for benefits. This eligibility data is provided to the Contractor for use with other subsystems and for on-line inquiries. Eligibility for the programs under this contract is determined by the Contractor by reviewing information accompanying the claim. Beneficiary eligibility is verified by the system for the date of service submitted by the provider. Once eligibility has been verified, the system performs further editing to identify payment restrictions (e.g. other health coverage, share-of-cost, restricted services).

2.2 OBJECTIVES

The following are the objectives of the Recipient Subsystem:

1) Identify all persons eligible for Medi-Cal, CCS, GHPP, CMSP, CTP, CHDP Gateway, and HF and any other claims processing or operational systems;

2) Provide timely replacement of Fiscal Intermediary Access to Medi-Cal Eligibility (FAME) file;

3) Maintain all data pertaining to recipient eligibility such as restricted services, other health coverage, Share-of-Cost (SOC), Long Term Care share-of-cost**,** and health care plan information;

4) Maintain recipient history to be used in the Claims Processing Subsystem, Management and Administrative Review Subsystem (MARS), Surveillance and Utilization Review Subsystem (SURS), and the Reference File Subsystems. Six years of data shall be maintained. No valid beneficiary history shall be purged;

5) Provide on-line access to eligibility data for State-authorized users;

6) Ensure continuity of eligibility history for each beneficiary regardless of changes in county of residence, aid category, periods of ineligibility, change in county-assigned number, or Medi-Cal Eligibility Determination System identification (MEDS ID) number;

7) Maintain all Automated Eligibility Verification System (AEVS) related transaction eligibility data; and

8) Maintain updated information of other health coverage and health insurance coverage on beneficiaries.

2.3 ASSUMPTIONS AND CONSTRAINTS

The Recipient Subsystem is subject to the following assumptions and constraints:

1) A Medi-Cal or CMSP applicant may become an eligible beneficiary at any time during any calendar month. However, the effective date of eligibility will be the first (1st) day of that calendar month and termination of eligibility will be at the end of a calendar month. An exception to this rule applies in the case of death (i.e., eligibility ends on the date of death versus the end of calendar month);

2) A Medi-Cal or CMSP beneficiary may have eligibility changes on a month-to-month basis. For example, a beneficiary may be eligible one (1) month, not eligible the next, and eligible again the third (3rd) month;

3) A Medi-Cal or CMSP beneficiary may have scope of eligibility changes within a month. For example, a beneficiary may be eligible only for restricted services at the beginning of the month and then may become eligible for full scope coverage within the month;

4) Eligibility for a CHDP Gateway beneficiary is under 19 years of age and will receive full-scope fee-for-service Medi-Cal and Denti-Cal benefits for up to two (2) months;

5) Eligibility for a CTP beneficiary is determined by information given on the child's Child Health and Disability Prevention (CHDP) Assessment form (PM160) (or equivalent/replacement). The date of eligibility will begin on the date of service on the CHDP PM160 form and ends when the child receives a new PM160. The Department anticipates implementing an electronic PM160 before contract effective date;

6) Eligibility for a Healthy Family beneficiary begins ten (10) calendar days from the date Healthy Families determines that a person qualifies for the program;

7) Eligibility for a CCS or GHPP beneficiary is day-specific, and can be established, updated, deactivated, or applied retroactively. Retroactivity can be for multiple months;

8) A beneficiary may have a SOC that is computed on a monthly basis. The program also allows payment to providers to be carried over to satisfy future SOCs;

9) A Medi-Cal beneficiary may be determined by the Department to be retroactively eligible for the three (3) months immediately prior to the individual's application for Medi-Cal;

10) A beneficiary may have eligibility under one or more aid categories during the same month;

11) A beneficiary's MEDS ID number can change;

12) A beneficiary may be identified by more than one MEDS ID number; these numbers must be cross-referenced by the Contractor using data provided by the Department; and

13) The fiscal intermediary (FI) for medical claims processing is responsible for support of the California Eligibility Verification and Claims Management System (CA-EV/CMS) can be accessed by the following:

    a) Point-of-Service (POS) Network, which is accessed via dial-up by a POS T7 device, CERTS, or approved vendor or user-developed/modified system or software;

    b) Leased-line connection with Health and Human Services Data Center (HHSDC);

    c) Automated Eligibility Verification System (AEVS) telephone/interactive voice response system; or

    d) Supplemental AEVS (SAEVS) System;

    e) Internet via the Medi-Cal Web site; and

    f) The CA-EV/CMS shall be available twenty-two (22) hours per day, seven (7) days per week.

2.4 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Generate all Recipient Subsystem reports produced by the CD-MMIS as set forth as described in Exhibit Attachment II, Operations, Requirements section, unless otherwise specified in this section;

2) Provide on-line access to the FAME file eligibility information for Department-authorized users via personal computer, as described in CD-MMIS On-Line Availability and Response Times. The access shall allow only inquiry and not update capability;

3) Maintain the weekly FAME files for use by CD-MMIS;

4) Maintain the replacement files provided by the Department, including eligibility, SOC, and any cross-reference transactions, and incorporate them into CD-MMIS within two (2) days of receipt;

5) Maintain the automated Share-of-Cost Master File (SOCMF), a centralized file of the SOC database. As each SOC is processed, the SOCMF must be updated with valid data, and records added and deleted as necessary. Update shall occur at least as often as the FAME is replaced. The MC177 facsimile shall be created, maintained, and retrieved during claims processing;

6) Maintain the permanent recipient MEDS ID cross-reference file for use in CD-MMIS. Cross-references to changed recipient MEDS ID numbers are required by the system in order to correlate an individual beneficiary's claims, regardless of identification number changes;

7) Maintain internal controls and audit trails for recipient eligibility files. Ensure that the Contractor recipient eligibility files are replaced only by Department-provided files. At the written direction of the Contracting Officer, the Contractor shall provide access to the Contractor's internal controls and audit trails within two (2) State workdays of the Department's request;

8) Maintain recipient information such as aid codes, Health Care Plan, Medicare data, restricted service information, other health insurance coverage, SOC, and Long Term Care SOC; and

9) Maintain the other health coverage and health insurance carrier information provided by the Department.

2.5 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Provide the Contractor with on-line access to FAME with a minimum of sixteen (16) months of eligibility data;

2) Provide the Contractor with a weekly copy of FAME on tape for disaster recovery purposes;

3) Provide the Contractor with other health coverage files and health insurance carrier information;

4) Provide the Contractor with AEVS transaction eligibility date from which the Contractor will extract Eligibility Verification Confirmation (EVC) and SOC information;

5) Develop and maintain policy regarding beneficiary eligibility;

6) Provide cross-reference data for recipient MEDS ID number changes; and

7) Provide the Contractor with a replacement file of cross-reference data records.

3.0 PROVIDER RELATIONS SUBSYSTEM

3.1 OVERVIEW

The Provider Relations Subsystem is to provide centralized control of required data using CD-MMIS for all Medi-Cal dental providers. Provider Support Services acts as a support activity for claims processing, management reporting, and surveillance/utilization review reporting.

The Provider Relations component of the Contractor's organization serves as the primary source of communication between the Medi-Cal dental providers, billing intermediaries, the Contracting Officer, and Contractor personnel. Therefore, the Contractor shall have primary responsibility for: enrolling, entering and updating provider related data on the Provider Master File (PMF) in a timely manner. Further delineated and described throughout this section, the Contractor's responsibilities include:

1) Provider and Billing Intermediary Enrollment;

2) Provider Master File (PMF);

3) Provider Publications and Forms;

4) Printing and Distribution of Forms;

5) Provider Support Services;

6) Provider Outreach;

7) Provider Training; and

8) Provider Telephone Service Center (TSC) Operations.

3.2 OBJECTIVES

The objectives of the Provider Relations Subsystem are to:

1) Process data changes submitted by providers within ten (10) State workdays of receipt;

2) Ensure that billers and billing intermediaries submitting claims through the Medi-Cal Dental Program, Electronic Data Interchange (EDI) media and hard copy, are qualified under the State's regulations and are able to submit claims that are technically complete;

3) Ensure billing intermediaries who bill the Medi-Cal Dental Program on behalf of providers are enrolled with the Contractor;

4) Ensure providers are given an explanation on the status of their suspended TARs via the Explanation of Benefits (EOBs);

5) Ensure providers with compatible computer systems (hardware and software) can submit claims/TARs/NOAs/CIFs/RTDs electronically;

6) Support the Claims Processing Subsystem, MARS, and S/URS;

7) Provide information to the Department to assist in the development of policies for the Medi-Cal Dental Program;

8) Ensure providers are qualified, according to Department regulations and policies, to render services under the Medi-Cal Dental Program;

9) Process informational updates to the PMF on an on-going basis;

10) Provide ongoing communication and training to providers regarding Medi-Cal dental regulations, procedures and policies utilizing provider manuals/bulletins, telephone/written correspondence, on-site visits, and provider seminars;

11) Ensure enrollment and certification requirements of Medi-Cal dental providers are met and that all enrollments are completed within ten (10) State workdays. Enrollment may not occur until all enrollment requirements have been met (e.g. on-site visit if applicable);

12) Provide information/assistance and required enrollment forms to providers that are interested in direct deposit of their provider payments;

13) Monitor enrolled providers monthly to ensure continued eligibility by verifying license status with the Dental Board of California;

14) Provide notification to providers within ten (10) State workdays of approval or rejection of their application to be a Medi-Cal Dental Provider;

15) Print, imprint and distribute claim forms, radiograph envelopes, and other required documents on paper and/or

electronic media to providers for claim/TAR/radiograph submissions; and

16) On an on-going basis monitor dental provider access problems in underserved areas within California and bordering communities in adjacent states.

3.3 ASSUMPTIONS AND CONSTRAINTS

Provider Relations Subsystem is subject to the following assumptions and constraints:

1) Prospective providers are responsible for initiating the application process, completing all enrollment forms, completing a provider agreement, and notifying the Contractor once enrolled if there are changes to their provider information;

2) Group dental practices, in their application, shall be responsible for reporting the name, address, license number, and provider number (if enrolled) of all dentists associated with the group practice;

3) A unique provider number will be issued to each eligible provider who applies for participation in the Medi-Cal Dental Program. The unique provider number may include multiple service offices;

4) Applicants meeting Medi-Cal Dental Program requirements are eligible to participate in the Medi-Cal Dental Program effective the date that all enrollment requirements have been met;

5) Receipt of a signed provider application/agreement and all applicable change forms/agreements constitutes a contractual relationship between the Contractor and the provider regarding the rendering of services for which the Contractor is the third (3rd) party payer;

6) Maintain established procedures with the Dental Board of California for verifying the licenses of dentists and for receiving information concerning the revocation of, or the placement of restrictions on licenses. Such procedures for new providers shall include license verification by means of the Dental Board of California website;

7) Provider Relations operates under the requirements of the Federal System Performance Review (SPR);

8) Out of State providers located in border communities of adjacent states shall be considered in-state providers for the purposes of this contract;

9) Providers must enroll in Electronic Data Interchange (EDI) in order to submit claims/TARs electronically; and

10) Providers must complete a direct deposit enrollment form in order to authorize direct deposit of their provider payments; and

3.4 CONTRACTOR RESPONSIBILITIES

3.4.1 GENERAL RESPONSIBILITIES

The Contractor shall:

1) Generate all Provider Relations reports produced by CD-MMIS. Reports must meet requirements set forth in the General Reporting Requirements section, unless otherwise specified in this section;

2) Identify and resolve provider problems by utilizing dental provider letters, CD-MMIS reports, dental claim inquiries, provider errors on claims/TARs, personal contacts with dental providers and dental provider associations;

3) Request written approval from the Department on any negative action(s) to be taken against a provider. The request shall be accompanied by supporting documentation. Negative actions are defined as special claims review, prior authorization review, suspension from the program, payment withhold, and levies. If acceptable to the Department, the Contractor shall place the appropriate indicator on the PMF in order to effect the negative action approved by the Department. Disenrollment of a provider may only occur when prior Department approval has been secured. When a provider is disenrolled an indicator shall be placed on the PMF to reflect that the provider is no longer active. Any such restriction or indicator shall not be removed without the Department's explicit authorization; and

4) Be liable for any payments made to ineligible providers.

3.4.2 EQUIPMENT

Provider Support Services staff shall be furnished with the necessary equipment to ensure effective operations and to meet all of the Contract requirements.

The Contractor shall:

1) Ensure that all staff, wherever located within Provider Services, have the same level of functionality and can effectively communicate among themselves and with other Contractor staff or the Department as necessary;

2) Provide all computer hardware (including laptop computers where appropriate) and software (including connectivity for facilitating access to information and communications); necessary to meet all contractual requirements;

3) Provide telephones and, where appropriate, pagers, cell phones, faxes and copiers; and

4) Ensure any computer systems or technologies employed by the Contractor to support the Provider Support Services operations have the capability to be expanded and/or upgraded in anticipation of new programs or program expansions that are likely to occur over the life of this contract. The systems/technologies must be compatible with the Contractor's and the Department's standards for hardware and software configurations.

3.4.3 PROVIDER ENROLLMENTS

The Contractor shall:

1) Ensure prospective Medi-Cal dental providers receive sufficient information to understand program requirements to enable timely and accurate processing of enrollment applications agreements, billing intermediary registration requirements, certification, etc. This shall include the review and processing of prospective dental provider application agreement packages, in accordance with California Code of Regulations, (CCR) Title 22, Sections, 51000.30, 51057, 51059, 51223, 51451, and 51466 as directed by the Department;

2) Obtain the most current list of new licentiates from the Dental Board of California following the State Board Examinations;

3) Upon receipt of an enrollment application package, ensure the following:

   a) Prospective provider has an active, unrestricted license to practice dentistry;

b) Prospective provider has completed and signed the appropriate provider application/agreement with the Contractor to abide by all policies, State and Federal regulations, and laws related to the provision of dental care services under the California Medicaid Assistance Program;

c) Prospective provider is not under suspension or otherwise declared ineligible by the Department or the Office of Inspector General from participating in the Medi-Cal Dental Program;

d) Prospective provider has declared any significant beneficial interest in another current or potential Medi-Cal provider's practice;

e) If provider's application is incomplete it shall be returned to the prospective provider for additional information and if the prospective provider does not respond to a request for additional information within thirty (30) calendar days of the request, the Contractor shall cancel the provider's request to enroll and inform the prospective provider of the action taken. Return any enrollment packet as unprocessed if the enrollee's name is different from his/her legal name. Should the provider's application request be cancelled, the Contractor will require that the prospective provider reapply with a new application package;

f) Requests for license verification and additional information from the provider are done concurrently, except for missing information needed for verification;

g) Border dental providers shall be required to submit proof of current, unrestricted licensure from the State where the practice is located when submitting a claim for out-of-state emergency services that have been provided. When an out-of State provider submits a request for reimbursement for services provided to a Medi-Cal beneficiary, the Contractor shall determine whether or not the provider is enrolled. If the provider is enrolled, the Contractor shall process the request for payment. If the provider is not enrolled, the Contractor shall deny the claim and within five (5) State workdays and mail to the out-of-state provider an explanation of the denial, an enrollment package, and a request for a copy of the out-of-state provider's license for verification and certification. Within ten (10) State workdays after receipt of the enrollment package the Contractor shall either enter the out-of-state provider into the PMF, if the

information is complete, or return the incomplete application to the provider; and

h) Request new enrollees using a fictitious name or "doing business as" to submit a copy of their fictitious name permit when enrolling under any name other than their legal name.

4) Upon completion of the enrollment process, the Contractor shall:

a) Retain hard copies of the application and provider agreement packages and all provider correspondences regarding the enrollment of providers for the term of the contract;

b) Require the new enrollee to submit a taxpayer identification number or Social Security number for the purpose of filing Federal and State taxes; and

c) Provide an Automated Eligibility Verification System (AEVS) Reference Guide to newly enrolled providers added to the PMF.

3.4.4 PROVIDER MASTER FILE

The Contractor shall:

1) Meet the Federal requirements for SPR. The basic purpose of the SPR is to evaluate the Department CD-MMIS to ensure its operation is effective and efficient, and to ensure that the claims processing and information retrieval system used by the program meets minimum operational performance standards on an ongoing basis. If the Department fails to meet the minimum passing score on the performance standards, the Department will be subject to a reduction in operational funds as defined in Section 1903(r) of the Social Security Act and 42 CFR 433.120. Performance standards establish levels of achievement that CD-MMIS must sustain in terms of accuracy, timeliness and cost. To the extent the Contractor fails to meet a Department directive/contractual requirement, the Contractor shall be liable for the lost/reduced federal funds;

2) Serve as a guide and to be used in a basic conceptual framework, the following is the performance standard for the Provider Relations Subsystem:

Eligibility: An accurate system of provider eligibility information must be provided.

a) Factor 3: Accuracy of the Provider Master File - to ensure that providers who appear as "active" on the provider master file are eligible to participate in the Medicaid program;

b) Factor 4: Provider File Updates - to determine whether provider status changes, entered into the provider master file, have been properly authorized according to Department procedures, and whether such changes are placed on the file timely;

c) Factor 5: Unique Provider Identifiers - to ensure that a single, active provider does not have multiple, uncross-referenced identification numbers; and

d) Factor 6: Rendering Provider Numbers for Group Practices - to ensure that services rendered by an individual provider in a group practice can be traced back to the individual provider a claim is processed for, even if payment for the claim was made to the group.

3) Update the PMF by entering transactions (e.g., add status, changes, and deletions) on-line; apply all Department approved edits to the transactions received and update the PMF on a daily basis. The provider count and status shall be computed after each update. Transactions determined to be in error shall not be updated to the PMF, but shall be corrected by the next day. Make the PMF available to the Department for on-line inquiry via the personal computer by 7:00 AM PST on the next State workday following the daily updates, unless otherwise directed by the Contracting Officer; and

4) Provide the Department with a copy of the PMF on media requested by the Department, within ten (10) State workdays of the Department's request. A maximum of twelve (12) copies shall be provided to the Department per calendar year.

3.4.5 BILLING INTERMEDIARIES/ELECTRONIC DATA INTERCHANGE (EDI)

Welfare and Institution Code 14040.5, as enacted by AB1251 (adopted in 1987), superseded by AB1098 (adopted in 2000) requires companies who bill the Medi-Cal Dental Program on behalf of providers, to register with the Department and include their registration number on all claims submitted. Failure to comply may result in claim denial and withdrawal of registration. This legislation also requires providers to notify the Department

when using billing companies. As used in this RFP, a billing intermediary does not include salaried employees of a provider; also, "provider" means any individual, partnership, clinic, group, association, corporation or institution as defined in CCR Title 22, Section 51051, and includes any officers, directors, agents, or employees thereof.

The Contractor shall:

1) Ensure a billing intermediary's registration form contains:

   a) A billing service name and address;

   b) A previous Contractor assigned registration number;

   c) A list of Medi-Cal dental providers who contract with the billing service, which includes each provider's name, dental license number, and the effective date of contracting with each of the providers;

   d) A return address for submission of the registration form; and

   e) Any entity including a partnership, corporation, sole proprietorship, or person that billed Medi-Cal on behalf of a provider pursuant to a contractual relationship with the provider.

2) Ensure the notification form for providers who use billing intermediaries contains the following information:

   a) Provider name/dental license number/address;

   b) A Doing Business As (DBA) name, along with supporting documentation such as local business license and a copy of valid legible fictitious name permit;

   c) A previously Contractor assigned registration number (when applicable);

   d) Billing intermediaries/services address(s);

   e) Effective date;

   f) Provider's original signature and date; and

   g) A return address for submission of notification.

3) Process system changes and methodologies that provide for acceptance and tracking of billing intermediaries who

register with the Medi-Cal Dental Program, or are identified based on notifications from providers in the Medi-Cal Dental Program who use billing intermediaries;

4) Approve, process, develop and maintain a tracking system of registration forms from billing intermediaries, and notification forms for providers who wish to register or have notified the Contractor of billing intermediary participation;

5) Certify and respond to the provider and/or billing intermediary submissions within ten (10) calendar days of receipt of registration application. The Contractor acknowledgment and response shall include a Contractor assigned registration number that will enable the billing intermediary to prepare and submit claims with a billing service registration number;

6) Update the PMF to identify those providers who use billing intermediaries;

7) Prepare/distribute provider bulletins regarding billing intermediary requirements as deemed necessary by the Department;

8) Incorporate billing intermediary requirements in all provider training sessions and applicable staff training sessions, and distributing registration and notification forms to attendees as requested;

9) Ensure CD-MMIS edits/audits are installed to verify claims have valid billing codes;

10) Ensure CD-MMIS has the capability to track via the billing intermediary's registration number and/or the provider number and generate a weekly report of such data;

11) Ensure that all billing intermediaries are registered with the Contractor and that the registration number is in the Remarks section of all claims submitted for payment;

12) Ensure that any Medi-Cal dental claim submitted by a billing intermediary who fails to comply with the requirements of this section or is involved in illegal submission of claims, may be subject to denial and/or result in the withdrawal of registration of the intermediary by the Department;

13) Process provider requests to discontinue or modify existing EDI/billing intermediary arrangements;

14) Process the submitted test documentation (measuring the applicant's technical ability to comply with the EDI billing

requirements), and respond to the applicant within ten (10) State workdays of receipt of the test documents; and

15) Update the PMF EDI Submitter File, and deliver copies of application form(s) and appropriate CD-MMIS reports to the Department within five (5) State workdays after approval of the test documentation.

3.4.6 PROVIDER PUBLICATIONS AND FORMS

The Contractor shall produce and provide publications on paper and/or electronic media to providers, billing agents, government and private entities using Department approved criteria. After Department review and approval, print and disseminate the Dental Provider Manual including replacement pages, priority bulletins, and general bulletins to providers regarding Medi-Cal, CMSP, CHDP Gateway, CCS/GHPP, CTP and Healthy Families dental related policies, procedures, statutes, and regulations.

Provider publication activities shall include the following:

1) Creation and formatting of provider publications as directed by the Contracting Officer, including those submitted to the Contractor in the form of DOILs, SDNs, Problem Statements, or contract correspondence, within ten (10) State workdays of a Department request, unless otherwise directed by the Contracting Officer. Additional provider publications may be written at the discretion of the Contractor; however, all provider publications shall be submitted to the Department for final approval prior to publication and distribution;

2) Request formal approval for publications from the Contracting Officer;

3) Development of provider publications and disseminate in accordance with the following definitions and time frames as determined by the Department;

4) Priority Bulletins - an issue of major importance to be mailed within six State workdays after Department approval. When a Priority Bulletin is not distributed within the required timeframe due to the fault of the Contractor, the bulletin shall be distributed at no cost to the Department;

5) Special Bulletin - an issue of importance to be mailed with fifteen (15) State workdays after receipt of Department approval;

6) General Bulletin - a compilation of bulletins to be mailed within fifteen (15) State workdays after Department approval;

7) Manual Replacement Pages - updates to the Medi-Cal Dental Provider Manual, to be developed and mailed within fifteen (15) State workdays after Department approval, along with the General Bulletin that announces the policy or procedural change(s);

8) Development of an index (by subject matter, article and bulletin) of all bulletins contained in the Dental Provider Manual. The index shall include all bulletins that are part of the provider manual and shall be updated at a minimum of every three months. The index shall be alphabetized by subject and shall indicate where the information may be found in the Manual. The updated index shall be distributed to providers and offices currently receiving bulletins within fifteen (15) State workdays after each update;

9) Quarterly, incorporate all changes to the Dental Provider Manual, (e.g., replacement pages and the subject index), into the masters used for making additional copies of the Manual, within thirty (30) State workdays after the first (1st) State workday of each calendar quarter. Also, the Contractor shall print and disseminate provider manual replacement pages within this same time frame;

10) Quarterly access the need to update the Desk Reference, and notify the Contracting Officer of the update and the projected cost associated. After each Department approval, the Desk Reference shall be published and distributed to the Department and all enrolled providers;

11) Process requests received by providers and the Department for Dental Provider Manuals in addition to those sent in the initial package during provider enrollment. The price for additional manuals will be established by the Department and the money collected shall offset the Contractor's cost reimbursement billings and are to be shown separately on the invoice. These additional manuals shall be provided to individuals requesting them within fifteen (15) State workdays of receipt of the request;

12) Within ten (10) State workdays after the Contractor places a newly enrolled provider on active status on the PMF, the Contractor shall, at a minimum, mail to the provider the following:

    a) A current (i.e. updated by date of the most recent Department approval) Medi-Cal Dental Provider Manual, Manual of Criteria including the Desk Reference and all related bulletins collated in chronological order;

b) An initial stock of claim forms, pre-imprinted with provider identifying data;

c) An initial stock of (TARs), and (CIFs);

d) An initial stock of envelopes for radiographs;

e) Claim and other document re-order forms; and

f) A current training schedule.

13) Maintain an on-line tracking system accessible to the Department that contains the following elements:

a) Bulletin Volume and Number;

b) Contractor accuracy editor's initials;

c) Contractor publications editor's initials;

d) Contractor receipt date;

e) Contractor accuracy editor receipt date and completion date;

f) Date bulletin article submitted by Contractor to Department for review;

g) Projected release date;

h) Department contact name;

i) Department approval date;

j) Date published;

k) Final copy mail date;

l) Date of posting on to the Department's electronic document tracking system, all bulletins, updates and new publications;

m) Number of published copies by provider type; and

n) Current status of the bulletin, sorted by volume and bulletin number in descending order.

14) Update the on-line tracking system within four (4) State workdays of any publication activity; and

i.15) Provide an explanation in writing, to the Department, of the reason(s) for each late approval of distribution, including any time delays in posting on the Department's electronic document tracking system.

3.4.6.1 PRINTING AND DISTRIBUTION OF FORMS

The Contractor shall:

1) Print and distribute to enrolled providers all CD-MMIS forms, envelopes and other materials as directed by the Department;

2) Pre-imprint claim/TAR forms (upon request of the provider) with provider numbers, name, full address, and other identifying information used by providers to bill the Medi-Cal Dental Program;

3) Use only those form masters approved by the Department;

4) Distribute to enrolled providers all the necessary forms and envelopes needed to interact with and bill the Medi-Cal Dental Program;

5) Maintain records of form inventories and records to substantiate the Contractor's response to provider requests for forms. The Contractor shall provide to the Department access to these records within two (2) State workdays of the Department's request. The records shall be kept by receipt date of the provider's request, and by date the requested forms were mailed to provider(s). The Contractor shall bring unusual form order requests to the attention of the Contracting Officer prior to filling the request;

6) Provide claim forms and procedural information to provider billing services that provide and/or bill for Medi-Cal dental services. The Contractor shall also provide the Department with forms needed by the Department for system testing;

7) Maintain thirty percent (30%) of a year's volume (the percentage of forms distributed in a year) as inventory of the forms and envelopes required to support CD-MMIS. The Contractor shall mail forms and envelopes to providers within ten (10) State workdays of receipt of the provider's reorder request;

8) Make available to providers two (2) different size envelopes: i.e., one that will accommodate full-mouth radiographs and a smaller size envelope to accommodate single tooth radiographs;

9) Utilize the nine (9) digit Zip Codes (Zip + 4) to presort outgoing mail; and

10) Comply with the U. S. Postal Regulations for all outgoing mail.

3.4.7 PROVIDER SUPPORT SERVICES

The Department recognizes that accurate and timely response to provider inquiries and issues directly affects healthcare entities' willingness to participate and deliver medically necessary dental care services to needy Californians. The Department further acknowledges that the longer it takes to respond to a provider issue, the amount of resources expended begins to climb exponentially. It is the Department's intent to have a provider support services operation that is highly responsive to provider needs and employs industry standards and technologies in its delivery approach.

The provider support services function includes receipt of and response to provider inquiries regarding Medi-Cal dental procedures, policies, regulations, and/or the status of TAR/claims submitted to the Contractor.

These staff shall only perform provider related activities as specified in this section or authorized by the Contracting Officer, and shall not be involved in the processing of claims/CIFs/TARs and other specialized documents. Additionally, staff shall only be involved in provider related activities involving providers associated with the Medi-Cal Dental Program, CMSP, CHDP Gateway, CTP, CCS/GHPP, and Healthy Families activities. If the need arises, staff shall be directed to identifying and resolving problems that providers are having in billing or in special projects as defined by the Contracting Officer working with the Contractor. Also, reference the Organization and Staffing Subsection, for additional information related to staffing requirements.

The Contractor shall:

1) Receive and respond to provider inquiries, via telephone, correspondence, and/or on-site visits;

2) Initiate provider support services activities that address concerns regarding the CD-MMIS raised to the Contractor or the Department by individual providers or their associations, and which independently identify and address provider problems and concerns;

3) Actively review reports of provider billing and system errors, and coordinate activities with providers and other Contractor

staff to provide the information necessary to facilitate prior authorization and/or payment. Specifically, Provider Support Services staff shall be utilized to research problems, review reports and initiate provider contacts to assist in correction and/or billing problems. When system problems are identified, Provider Support Services staff shall initiate the activities necessary to identify the individual providers affected by the system problem, and with other Contractor staff to reach resolution. The Contractor shall also research and respond to provider inquiries referred by the Department; and

4) Conduct provider training and recommend to the Department, improvements to increase provider satisfaction and participation in the program.

The Contractor shall perform the following core duties in relation to Provider Support Services operations:

1) Act as the communication liaison between dental providers and the Department;

2) Provide on-site assistance at the provider's place of business to address questions or concerns about program policies, law, regulations, and claim issues;

3) Contact newly-enrolled dental providers after they have been enrolled for three (3) months to ensure they understand Medi-Cal Dental Program requirements, the Medi-Cal dental billing process, and the availability of specialized training for their office staff, if necessary;

4) Answer all correspondence and appeals regarding Medi-Cal dental policy, procedures, regulations and statutes;

5) Process priority mail; misdirected mail; requests for interim payments; returned checks, warrants, money orders, etc.; miscellaneous correspondence; and mutilated claims. In addition, staff shall ensure claims/TARs are re-adjudicated, if applicable;

6) Mail a written acknowledgement of any correspondence received within five State workdays after receipt. A final written response shall be made within twenty (20) State workdays of receipt of provider correspondence or appeal, unless additional time for a particular type of correspondence or appeal is approved by the Contracting Officer;

7) Locate radiographs separated from documents during processing and/or logging, facilitate their return to the provider, and receive/process CIFs from providers;

8) Compile separate daily logs and files of all correspondence inquiries and provider appeals, and provide the Department, within two (2) State workdays, access to all daily logs and files upon request. The daily logs shall include the number of appeals or inquiries received, listed by provider specialty; category of questions asked by providers; and actions taken. Daily logs and files shall be maintained for the life of the contract. For retrieval purposes, provider correspondence and appeals shall be maintained by author and are subject to the requirements in Exhibit A, Attachment II, Operations, Records Retention Requirements Section;

9) Coordinate and conduct training seminars for providers regarding program policies, laws, regulations, and claim issues;

10) Respond to written requests and telephone inquiries from providers requesting program information or billing assistance;

11) Research billing problems that the Provider Telephone Service Center could not resolve and contact the provider(s) with a response;

12) Process provider refund checks, returned warrants, and provider inquiries on lost warrants;

13) Refer providers suspected of fraud or abuse to the Contractor's S/URS operation for further review and applicable action(s);

14) Oversee all telecommunication hardware and software for proper working condition for the ongoing operations of the Provider Support Services activities;

15) Order, maintain, and support all telecommunication lines necessary for the support of all components with the Provider Telephone Service Center;

16) Maintain all Provider Support Services files, reports and training schedules;

17) Ensure all components relative to the requirements of the Provider Support Services operations are fully operational with the startup of TAR processing; and

18) Unless otherwise stipulated, all Provider Support Services activities shall be available Monday through Friday, 8:00 a.m. – 5:00 p.m. PST, excluding State holidays.

3.4.7.1 ON-SITE PROVIDER VISITS

The Contractor shall:

1) Ensure Provider Support Services staff have access to applicable on-line files, screens, records and paper documentation to research provider concerns;

2) Initiate contact and visit those providers with high error rates or when claim/TAR documents demonstrate an obvious misunderstanding of the Medi-Cal Dental Program. Conduct on-site training sessions for groups of providers having similar billing difficulties;

3) Conduct new and continued re-enrollment on-site visits for all applicants;

4) Send a Provider Services Representative to a provider site when:

   a) A provider or representative of the provider (e.g., billing intermediaries) requests a visit. When a provider requests an on-site visit, the Contractor may attempt to resolve the problem(s) via telephone or correspondence. If the problem(s) cannot be resolved via the use of the telephone or by correspondence, the Contractor shall, with the concurrence of the provider, send a Provider Services Representative to the provider's site within twenty (20) State workdays after initial request by the provider/billing intermediary;

   b) The Department requests an on-site provider visit. The Contractor shall, with the concurrence of the provider, send a Provider Services Representative to the provider's site within ten (10) State workdays of the Department's request. The Contractor shall provide the Department with a written report of the visit within five (5) State workdays after the visit; and

   c) The provider agrees that the provider's submission of claims/TARs could benefit from an on-site visit.

5) Determine who within the Provider Support Services staff resolves specific provider problems and/or concerns;

6) Ensure that Provider Services Representatives document on-site visits by filling out a Contractor designed, Department approved standard form. Both the provider and the Provider Services Representative shall sign the form with each party retaining a copy. The Contractor shall provide the Department documentation of on-site visits within five (5) State workdays prior to the on-site visit. Copies of this documentation shall be maintained by the Contractor for the life of the contract. Final resolution of any unresolved issues shall be made in writing within twenty-one (21) calendar days after the on-site visit; and

7) The Contractor shall maintain, and provide access to the Department within two (2) State workdays of the Department request, all documentation and files pertaining to the activities of the Contractor's Provider Services Representatives.

3.4.7.2 PROVIDER OUTREACH

The Contractor shall:

1) Submit a plan to the Department for review and approval, to remedy the dental access problems in underserved areas within California and the border communities. Areas that are to be targeted for outreach activities will include any area with a low utilization rate (defined by the federal courts as forty-one point seventeen percent (41.17%), or areas that appear to be in danger of low/decreased utilization;

2) Initiate a process to contract with one or more entities to provide additional dental services in either fixed facilities (i.e., existing dental offices or clinics), or through the use of portable dental equipment (i.e., mobile clinics) in the underserved areas;

3) Initiate a process whereby beneficiaries in the underserved areas are contacted directly to ensure they are aware of their Medi-Cal dental benefits and that they have access to a Medi-Cal dental provider within a reasonable distance;

4) Ensure that new Medi-Cal dental providers are established in the underserved areas;

5) Within the approved access problem plan there shall be an evaluation of the accessibility to Medi-Cal dental care providers throughout the state, including which Medi-Cal dental providers (by Provider Number) serve which cities, counties and geographic areas of the state; whether dentists provide general dentistry or specialties, by type of specialty;

whether they are currently accepting new Medi-Cal patients; and current addresses/telephone numbers of their locations of practice. This information shall be continuously updated on an on-line system as changes occurred to previously gathered and recorded information received by the Contractor. The on-line system shall be made available to approved Contractor staff as well as the Department;

6) Conduct semi-annually survey Medi-Cal dental providers, in a form and manner prior approved by the Department. This survey shall query providers regarding the points addressed in the paragraph above;

7) Based on the survey results, the Contractor shall develop and maintain a referral system for beneficiaries. This referral system shall provide beneficiaries with three provider names, addresses, phone numbers and specialties of dental providers who are in their geographical location, and who are currently accepting new Medi-Cal patients. In areas where more than one provider fits these specifications, the system shall refer beneficiaries to all such providers, or to at least three (3) such providers, on a rotational basis to ensure each enrolled provider receives an equal share of the referrals. Referrals shall be in a manner that ensures that neither the Contractor nor the Department is perceived as recommending a particular provider or assuming responsibility for the quality of care rendered by any provider; and

8) Develop and recommend methods to assist beneficiaries' ability to access Medi-Cal dental providers in identified underserved areas.

3.4.7.3 PROVIDER REFERRALS FOR BENEFICIARY ACCESS

The Contractor shall:

Respond to beneficiary or Department inquiries on the same day the inquiry is received, to the extent possible. If a "same day" response is not possible, the response to an inquiry (i.e., the referral) shall be made within five (5) State workdays from receipt of the request. All referrals, whether "same day" or within five (5) State workdays shall be confirmed in writing to the beneficiary. Confirmation letters shall be generated and mailed the next working day following the inquiry. The Contractor shall document the activities related to individual access questions. The following documentation shall be made accessible to both Department and approved Contractor staff via an on-line database:

1) Log number of request;

2) Name of beneficiary and their Medi-Cal identification number;

3) Referring agency or name of beneficiary's authorized representative (if applicable);

4) Address, including zip code, and phone number of beneficiary;

5) Date inquiry received;

6) Type of service sought (general dentistry, specialty, emergency, etc.);

7) To whom referred by provider name, provider number, address of service location, including zip code, and phone number (multiple entries shall be made if appropriate);

8) Date referral made;

9) Whether the referral was made by phone or letter;

10) Any follow-up activity, feedback from beneficiary or referring agency; and

11) Complaints received, date received, and date referred to the Contractor's complaints/grievance operation. Referral to the complaints/grievance operation shall occur no later than the next working day following receipt of the complaint.

The above information shall be retained by the Contractor and used as back-up documentation for the Contractor's on-going monitoring of statewide accessibility to dental care. This information shall be processed daily and updated on the database of accessibility information as well. This information, including raw data and working papers, shall be kept for the term of the contract and shall be available to the Department upon request.

NOTE: If the beneficiary, or referring agency, complaint is that access was not achieved when the provider(s) to whom they were referred was contacted, additional referrals shall be given. This type of complaint, unless complicated by other factors, shall not be referred to the Contractor's complaint/grievance operation. Rather, resolution of the problem shall be sought within the same time frame set for resolving the original request. Additionally, the Contractor shall call the provider(s) to whom the referral was made as soon as they are told that the referral has been denied by the provider. This call shall be made to verify whether or not

the provider is currently accepting Medi-Cal patients and, if not, to encourage them to do so. If needed, the Contractor shall utilize the Outreach Dental Consultant to make and support these contacts. When verification of any changes has been received from the provider the on-line database shall be immediately updated with the new information.

3.4.7.4 PROVIDER TRAINING

The Contractor's Provider Support Services staff shall include a Training Coordinator/Trainer to ensure:

1) All providers receive sufficient information to allow them to properly bill the Medi-Cal Dental Program. Provider training shall relate to the scope of Medi-Cal dental benefits, TAR and claim billing procedures, and any modifications to those procedures that may be necessary due to changes in the dental program;

2) The Contractor shall provide a proposed training plan for Department approval, including a training syllabus, for each scheduled seminar no later than thirty (30) State workdays prior to each session which shall include:

   a) Definition of critical subject areas to be presented during the seminar (e.g., dental policies and procedures, CD-MMIS orientation, refresher courses, etc.);

   b) Training methodology, which includes training objectives(s), curriculum overview, and lesson plan outline (i.e., training syllabus); and

   c) A description of the professional background, skills, knowledge of subject matter, training experience, and qualifications of proposed training seminar leader(s).

3) The Contractor's provider training program shall include provider seminars and shall meet the following requirements:

   a) The Provider Training Manual shall include a description of each training course and shall be updated every six (6) months with updates delivered to the Department five calendar days following each update;

   b) Plan and schedule provider training seminars at a minimum of six (6) months in advance of the training date(s) and submit the schedule to the Department for approval. Upon Department approval, the Contractor

shall include the schedule in the next provider bulletin issued unless otherwise directed by the Department. In addition to furnishing providers a training schedule, the Contractor shall again notify providers of scheduled training thirty (30) calendar days in advance of the training date(s) and request a response from providers as to whether or not they plan to attend the training; and

c) Training shall be conducted in nine (9) areas of the State: Redding, Sacramento, San Francisco, Fresno, Los Angeles, San Jose, San Bernardino/Riverside, Orange County, and San Diego.

4) In each of the nine (9) areas the Contractor shall provide one basic seminar per area every three (3) months, for a total of thirty-six (36) basic seminars each contract year. Each of these seminars shall include training on the processing of claim forms/NOAs, TARs, CIFs, RTDs, provider appeals, and the automated telephone system, the Interactive Voice Response System. During each basic seminar the Contractor shall provide other appropriate information that will assist providers to understand program policies and regulations governing the Medi-Cal dental criteria, changes in Medi-Cal beneficiary identification and eligibility verification, as well as information on how to complete and interpret all documentation required in order to obtain prior authorization and/or payment. These seminars shall be general in nature and shall include all processing forms;

5) Seminars shall include an orientation on provider enrollment, provider agreements, and certification procedures. Seminars shall be scheduled to allow as much time as necessary to cover subject matter and allow for a question and answer period;

6) In addition, the Contractor shall hold advanced provider seminars (one (1) per area every six (6) months, and in between, determine the six (6) areas that would benefit most from another advanced seminar) for a total of twenty-four (24) advanced seminars each contract year. The advanced seminars shall include at least one (1) licensed dentist from the Contractor's staff to address the more technical and clinical components of the Medi-Cal Dental Program. Major areas to be discussed in detail at the advanced seminar, at a minimum, shall include such topics as Medi-Cal dental criteria, radiographs requirements, documentation requirements, claims processing codes, and common billing problems. A combination of a basic and advanced seminar (total of eight (8) hours of instruction) shall be considered a workshop;

7) Ensure that providers who attend the advanced seminars are eligible for four (4) units of continuing education credit. Those attending the basic seminars are eligible for three (3) units of continuing education credits and workshop participants are eligible for six (6) units. The Contractor shall establish and maintain relationships with the Dental Board of California for the continuance of this benefit;

8) Conduct special provider training sessions necessitated by major program changes (e.g., changes in scope of benefits, billing procedures or other major policy or procedure change) that exceed those of the otherwise mandated training requirements. The training shall be conducted by existing Contractor staff and shall be provided at the request of the Contracting Officer. This training shall be part of the Contractor's fixed price bid, except that the cost for rental charges incurred for the provision of adequate meeting space shall be paid by the Department on a cost reimbursement basis if these costs are incurred by the Contractor (see Cost Reimbursement section);

9) Make appropriate changes as deemed necessary by the Contracting Officer in cases where the Department disapproves Contractor recommendations (e.g., staff trainers, training courses, course content, method of presentation, training plans, training manuals, training site, updates, and status reports). Any changes, including those to the training schedule, seminar agenda, or training course contents, must be approved by the Department prior to the change(s) being implemented;

10) At each session make available evaluation forms enabling participants to evaluate the training course. The Contractor shall provide a summary of all participant evaluation comments to the Department within five (5) State workdays after each training seminar. The Contractor shall maintain copies of these forms for the life of the contract. The Contractor shall provide the Department copies of the completed evaluation forms within five (5) State workdays after the Department request. Any modifications to the training evaluation forms must be approved by the Department prior to the change(s) being implemented;

11) All training seminars shall be open to State and federal personnel;

12) Represent the Department at all approved Health Fairs and conventions; and

13) Make educational material available on VHS or CD ROM to providers, which contain training information presented in the Basic and Advanced Provider Seminars.

3.4.7.5 PROVIDER TELEPHONE SERVICE CENTER (TSC) OPERATIONS

There are different telephone activities to be supported by the Provider Telephone Service Center that have specific requirements (e.g., tasks to be performed and specific hours of operation). The Contractor shall provide the telephone system along with current technologies (e.g., call tracking, traffic management and reporting, quality assurance processes, on-line access to claim images) to support effective provider service operations and meet all applicable performance standards, including voice mail capability during non-operating hours.

The Contractor shall:

1) Respond to all telephone inquiries from providers, billing agents, Department, and/or Contractor staff. Telephone assistance shall include:

   a) Answering incoming calls;

   b) Making outbound calls to return voice messages received after regular business hours within one (1) State workday of receipt;

   c) Making outbound calls to follow up on inquiries that could not be completed during the initial incoming telephone call;

   d) Escalating calls, where appropriate, to supervisors within Provider Relations Operations or to other areas of the Contractor's organization, as applicable;

   e) Setting up a referral for a field representative visit; and

   f) Providing other pertinent telephone numbers to the caller.

2) Maintain and operate an integrated Provider Telephone Service Center that will incorporate all of the call center activities listed in this contract. This is in recognition that there are currently multiple call center activities, each with their own organization and separate telephone numbers. This can lead to confusion as to where to call, inefficiency in the operations, and inconsistency in the levels of customer service across all provider toll-free telephone activities;

3) Propose and provide sufficient providertoll-free lines, all necessary telephone system infrastructure and support, and maintain toll-free business lines for theProvider TSC in order to meet all Provider TSC requirements;

4) Operate and maintain a TSC organization, as proposed in the technical proposal and approved by the Department, to include:

   a) The proposed organization with the staffing identified;

   b) The number of 800 numbers to be utilized for access to TSC; and

   c) The proposed call vectoring scheme for the entire TSC.

5) Operate the Provider TSC in a manner that shall:

   a) Meet all of the requirements of this contract;

   b) Create an efficient Provider Service Center operation; and

   c) Produce consistency in terms of customer service across all Provider TSC functions.

6) Provide a Provider TSC that is user friendly for the callers by:

   a) Routing the caller to an operator or Interactive Voice Response System within four (4) telephone vectoring prompts; and

   b) Easily allowing the caller to navigate through the IVR.

7) Staff and maintain a Provider TSC system to handle incoming and outbound call volume between the hours of 7:00 a.m. to 5:00 p.m. PST, Monday through Friday and Saturday from 8:00 a.m. to 12:00 p.m., excluding state holidays, unless stated otherwise in this section. After regular business hours, provide an automated message system to collect caller information (e.g., voice mail);

8) Ensure the Provider TSC system unscheduled downtime does not exceed one-half (0.5) hour for any given month. In the event of system failure the Contractor shall:

   a) Notify the Department of any incident of Provider TSC downtime within one (1) hour of the incident, or as soon as the Contractor is aware of the interruption. As

soon as the cause and projected duration of the unplanned interruption is known, the Contractor shall provide that information immediately to the Department;

b) Within twenty-four (24) hours of the systems repair, notify the Department in writing of the actual cause, all areas impacted, the measurements taken to correct the problem and what additional measures have been put into place to prevent the problem from reoccurring; and

c) Provide an electronic notice to applicable contractor staff and the Department of any planned system interruption, shutdown, or file non-access, at least three (3) workdays prior to the system interference.

9) Ensure the number of Provider TSC personnel can adequately address the call volumes in order to meet performance requirements. (Historical call volume details can be found in the Data Library during the procurement process);

10) Ensure Provider TSC have claims processing background and good customer service skills to resolve complex problems via training and work experience;

11) Ensure the Provider TSC meet or exceed the following:

a) The weekly average number of incoming calls that are blocked (calls receiving a busy signal) shall be no more than seven percent (7%); i.e. the P factor;

b) The weekly average abandon rate shall be no more than seven percent (7%). A call will be considered abandoned when a caller chooses to disconnect after the introductory message and prior to being connected to an operator or voice mail;

c) The weekly average wait or hold time shall not exceed sixty (60) seconds;

d) All calls must be answered within three (3) rings (a call pick-up system that places the call in queue may be used);

e) All Department requests for placement of hold messages or music shall be executed within twenty-four (24) hours of the request; and

f) All voicemail calls shall be returned within one (1) business day.

12) Provide computer telephony equipment for the provider toll-free telephone lines which includes the following technology:

a) A PBX switch and all required hardware needed for Computer Telephony Integration (CTI). The switch must allow integration with other technologically advanced systems;

b) Equipment required to achieve operational requirements;

c) Management of call traffic through the use of computer-based systems;

d) CTI equipment must allow for future upgrades and additions of current computer telephony applications;

e) On-line, real-time interactive server capable of serving all provider toll-free telephone line, staff, and supervisors; and

f) Provider toll-free telephone lines support of interconnectivity among the various call center activities under the provider telephone service center umbrella.

13) TDD phone line(s) to provide services to hearing-impaired providers and/or billing agents.

3.4.7.5.1 PROVIDER TELEPHONE SERVICE CENTER RESPONSIBILITES

Provider Telephone Service Center shall:

1) Research provider telephone inquires via personal computers, using CD-MMIS files and digitally stored/imaged claim copies, and other available systems provided by the Contractor;

2) Respond to provider inquiries such as, but not limited to, Medi-Cal Dental and other covered health program billing procedures and issues, claim status, system problems, Erroneous Payment Corrections and general questions regarding policy and regulations;

3) Provide accurate and comprehensive responses to the caller (e.g., questions are thoroughly answered and/or, in the case of a billing issue, they are able to accurately correct a claim issue and resubmit the claim for a successful adjudication).

The exception should be if the issue is of a complex nature and requires detailed research; and

4) Refer inquiries, which cannot be answered immediately by the Provider TSC , to the correspondence and research staff or other appropriate provider relations staff for more complete and intensive research.

3.4.8 ORGANIZATION AND STAFFING

3.4.8.1 GENERAL RESPONSIBILITIES

The Contractor shall ensure sufficiently qualified staff is employed to meet all Provider Relations duties/responsibilities identified within this section. Selected functions within Provider Relations have specific staffing requirements and/or limitations on work activities. Ensure sufficient management staff are made available to participate in management control of activities, attend planning/problem resolution meetings, etc., as well as provide sufficient clerical and administrative support staff necessary to meet all contract requirements. Provide staff with all necessary computer resources, equipment and materials, i.e. on-line systems access, telephones, publications, reports, manuals, etc., which are necessary in the performance of their assigned Provider Relations activities. Access to dental professional staff shall be made available 8:00 a.m. – 5:00 p.m., PST, Monday through Friday, excluding State holidays, unless stated otherwise in this section, to address/resolve provider-related clinical issues.

3.4.8.2 FUNCTIONAL AREAS AND REQUIREMENTS

1) Provider Appeals - Resolves provider complaints/grievances concerning the processing of TARs/claims for payment of services provided under the Medi-Cal Dental Program; receives, acknowledges, investigates, processes, tracks and responses to appeals; and prepares reports as necessary;

2) Provider Enrollments - Responds to provider inquiries regarding enrollment procedures; processes enrollment applications; processes provider agreements; issues provider Personal Identification Numbers to enable provider's access to the IVR system; enrolls billing intermediaries; maintains the PMF; verifies providers' licensing requirements; tracks provider enrollment documents; and prepares reports as necessary;

3) Provider Publications and Forms - Creates, edits, publishes, and distributes provider manuals, bulletins; coordinates both with in-house facilities and outside vendors on the

production of provider manuals, provider manual replacement pages, desk reference, provider bulletins including general as well as priority bulletins;

4) Provider Support Services - Researches/responds to provider telephone/written inquiries, makes on-site provider office visits for training/problem resolution purposes, prepares training plan, outlines training course, and conducts provider training seminars. Locates radiographs that have been separated from documents during processing/logging and facilitates return to the appropriate dental provider's office; researches, evaluates, resolves, responds, and logs provider inquires and/or appeals; researches documents which are delayed in processing or needed to resolve inquiries; receives, processes and readjudicates CIFs from providers; retrieves microfilm copies of documents; logs, tracks, and reports on functional responsibilities as necessary;

5) Provider Outreach – Coordinates, oversees, recruits and monitors beneficiary access to provider services statewide, in border communities, and in those areas that appear to be in danger of low declining utilization;

6) Provider Telephone Service Center- Receives, investigates and responds to inquiries from Medi-Cal dental providers and their office staff related to billing problems, prior authorization problems, missing radiographs; clarifies Explanation of Benefit (EOB) codes; answers questions related to dental program policies, procedures, processes, and regulations; and

   At a minimum, the Contractor shall maintain the following Provider Relations dedicated staff and shall work only on those activities identified throughout the contract. Any vacancies shall be filled within thirty (30) calendar days unless specifically exempted by the Contracting Officer:

   a) Provider Services Representative(s) - Staff must have dental background, and be able to work directly with providers and provider associations to resolve complex problems in addition to conducting training seminars;

   b) Correspondence Specialist(s) - Staff to arrange for the proper response order of all written materials, including the responses referred to Provider Support Services via the provider toll-free telephone lines staff;

   c) Provider Services Training Coordinator/Trainer(s) - Staff to prepare/present provider training seminars; and

d) Outreach Dental Consultant - At a minimum, there shall be one Dental Consultant (California licensed dentist) dedicated to this function that shall coordinate, oversee, and travel statewide to recruit/retain providers for the Medi-Cal Dental Program. The primary focus shall be to ensure provider access meets the needs of the Medi-Cal Dental Program.

7) The Contractor shall maintain a sufficient Provider Telephone Service Centerfor the provider toll-free telephone lines, however, the Contractor may direct the provider toll-free telephone lines staff to the beneficiary toll-free telephone lines and visa versa to better meet the needs and demands of providers and beneficiaries. In addition, the Contractor Telephone Service Center shall be at the ratio of three (3) operators for every four (4) toll-free lines with all operators having had provider relations or claims processing experience and at least four (4) of every five (5) operators shall be dental paraprofessionals. A minimum of P Factor seven percent (7%) shall be maintained.

3.4.9 REPORTS

Provider Subsystem reports produced by CD-MMIS must meet requirements described in the General Reporting Requirements section, unless otherwise specified.

The Contractor shall submit to the Department the following information:

1) Provider Support Services

A monthly report shall be delivered to the Department no later than the fifth (5^{th}) State workday of each month, to include:

a) Provider related problems summarized by category and source;

b) Actions taken by the Contractor to resolve problems or to allow providers to correct the problems;

c) A narrative description of the actions the Contractor plans to take to resolve problems and a time schedule for each action/activity the Contractor proposes to take;

d) A listing of the providers visited during the report month, summarized by provider specialty, provider representative, nature of the problem, and the training and/or assistance provided; and

e) Proposed changes, if any, in the required Provider Support Services.

2) Billing Intermediaries/EDI

Produce weekly/monthly reports for the registration and/or notification of billing intermediaries. Reports must meet requirements described in the General Reporting Requirements section.

3) Provider Enrollment

a) Produce a monthly report that includes the volume of outgoing mail associated with provider enrollment by type and costs (total and by price) for each week, and a monthly summary;

b) Produce a monthly report that measures the number of pieces of provider enrollment mail returned as undeliverable and action(s) taken to correct addressing deficiencies; and

c) Produce a monthly report (report shall include city where providers practice exists) to capture number of applications received:

1) New enrollment applications;

2) Re-enrollment applications;

3) Changes to supplemental application; and

4) Denied applications.

4) Provider Telephone Service Center Operations

Produce and deliver to the Department weekly hardcopy reports showing the following:

a) Statistics of all completed calls: Number of attempts, completions, retries, average minutes holding time, average length of calls, number of busy signals and number of abandoned calls. Analysis of this data, sampled in two (2) hour intervals, by day;

b) Percentage of connected calls vs. non-connected calls and/or busy signals, (i.e., “P” grade of service), by week; and

c) The type of contact (toll-free telephone or written communication); the information sought or the complaints received by summary categories that have been prior approved by the Department;

5) Publications and Forms

a) Report the total number of impressions for each type of publication issued each month. The Contractor's report shall include the number of bulletin pages and manual replacement pages within each provider manual bulletin package. This report shall be completed and submitted to the Department no later than the twentieth calendar day of each month;

b) Report the total number of impressions for each provider community and the totals for the month;

c) Report a comparison of the total number of pages and impressions of the current calendar month and year with the previous calendar month and year;

d) Report the mail date of all publications including general bulletins, priority bulletins, provider letters, and training materials;

e) Report the number of days between the receipt date of the publication request and the date the request was routed to the Department for approval; and

f) Report the number of new provider manual orders processed for newly enrolled providers and new subscribers, as well as the number and type of deactivated providers and cancelled subscribers. The report shall also include the date the request was made (i.e., the request date) and the date the request was processed/completed (i.e., response date).

6) Provider Outreach

For the purpose of Provider Outreach, the Contractor shall submit to the Department on a weekly basis the following information:

a) Number of beneficiary referral requests received each week;

b) Number of referral requests unresolved from previous weeks;

c) Number of beneficiaries referred to Medi-Cal dental providers, by type of practice (general dentistry or specific specialty), and geographical location;

d) By geographical location, the provider names, provider ID numbers, and the type of practice (general dentistry and/or specific specialty) of Medi-Cal dental providers who are currently accepting new Medi-Cal patients;

e) By geographical location, the provider names, provider ID numbers, and the type of practice (general dentistry and/or specific specialty) of Medi-Cal dental providers who are currently treating Medi-Cal patients, but who are not accepting new Medi-Cal patients;

f) The mode, median and mean span of time (in days) from the request for access information by the beneficiary or one of the client groups listed above to the time of the referral received that week;

g) The mode, median and mean span of time (in days) from the request for access information by the beneficiary or one of the client groups listed above to the time the weekly report was generated for the unresolved requests for referral to a Medi-Cal dental provider who is accepting new Medi-Cal patients; and

h) The Contractor shall submit a quarterly report to the Department identifying counties where it is difficult to find providers who are accepting new Medi-Cal beneficiaries or where providers are refusing to offer service Medi-Cal dental beneficiaries. This report shall be due ten (10) days after the end of each quarter, and shall identify the county or counties and a list of recommendations as to how these problems can be resolved. These recommendations will be reviewed by the Department to determine what corrective measures should be pursued.

3.5 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Review and approve, if acceptable, all application/agreements and the provider enrollment package that shall be sent to prospective Medi-Cal providers;

2) Review and approve, if acceptable, the Contractor's procedures for certifying that a provider is eligible to enroll in the Medi-Cal Dental Program;

3) Review and approve, if acceptable, the Contractor's requests to take negative action against a provider. Following approval, the Department will instruct the Contractor to indicate on the PMF the negative action to be taken. The Department also retains the authority to initiate negative action against a provider independent of the Contractor's request;

4) Identify providers to be disenrolled from the Medi-Cal Dental Program and instruct the Contractor to initiate action resulting in the disenrollment;

5) Continue to define those areas adjacent to California that qualify as border communities of adjacent states;

6) Review and approve, if acceptable, the Contractor's schedule of provider training seminars; the agenda, description of the training content, training site, handouts for each seminar; and any changes thereof;

7) Review and approve, if acceptable, the evaluation forms used by providers to evaluate training sessions, and any changes thereof;

8) Review and approve all provider manuals, manual replacement pages, provider bulletins, desk references and bulletin articles prepared by the Contractor prior to release;

9) Develop Medi-Cal dental policy related to Provider Support Services and its functions;

10) Review and approve documentation relating to providers who are subject to special prepayment review, including prior authorization status;

11) Review and approve, if acceptable, the Contractor's procedures for telephone responses, correspondence responses, provider relations activities, and any changes thereof;

12) Review and approve, if acceptable, all CD-MMIS forms utilized by providers to interact with the Medi-Cal Dental Program, prior to distribution to the providers;

13) Monitor provider training, provider publications and provider relations to maintain integrity and consistency;

14) Review and approve, if acceptable, modifications that provide for the registering of billing intermediaries. In cases where the Department disapproves any aspect of the

modifications, the Contractor shall be directed to make the updates as deemed necessary by the Department;

15) Monitor the PMF and subsequent CD-MMIS reports of billing intermediary services;

16) Determine all policy, registration, and/or withdrawal of registration of a billing intermediary;

17) Review and approve, if acceptable, all material distributed to providers;

18) Participate in consultations with providers and provider associations; and

19) Review and approve, if acceptable, any modifications to the provider suspense notification of TAR explanation codes created for TARs “In Process.”

4.0 REFERENCE FILE SUBSYSTEM

4.1 OVERVIEW

The Reference File Subsystem collects and maintains the files used to price and pay claims as well as the edits and audits criteria table files used to apply program policies and procedures. These files contain information needed primarily by the Claim Processing Subsystem to ensure that claim/TARs are consistent with program policies and procedures and are priced correctly. Information contained within the Reference File Subsystem is also utilized by the Management Administrative Reporting Subsystem (MARS) and the Surveillance and Utilization Review Subsystem (S/URS).

4.2 OBJECTIVES

The objectives of the Reference File Subsystem are to:

1) Accumulate and maintain accurate adjudicated claim and TAR history;

2) Maintain an accurate history of pended claims;

3) Maintain accurate and up-to-date files of history cross-check procedures, procedure codes, recipient age matches, etc., to facilitate proper adjudication of claims;

4) Provide the Claim Processing Subsystem with edit and audit criteria tables approved in advance by the Department;

5) Support the simulation of edit and audit activity in a test mode without impacting normal processing;

6) Generate various listing of the content of each file within twenty-four (24) hours of the Department's request. This includes procedures/pricing, edit/audit criteria, pending TARs/claims, adjudicated claims history, TAR masters, archived claims and TARs;

7) Update files in an accurate, efficient and timely manner;

8) Provide a database for the detection of duplicate and/or conflicting claims and TARs;

9) Provide the Department, the Claims Processing Subsystem, and other subsystems with provider and recipient claims/TARs history;

10) Provide on-line visual display to rapidly identify the status of a claim/TAR within the Claims Processing Subsystem;

11) Edit all transactions to the Reference File Subsystem and modify the files, in a manner approved by the Department, if the transactions are valid;

12) Reject defective fields or records in error and place on reports;

13) Provide edit tables to identify services that have potential third (3rd) party liability (TPL);

14) When services require prior authorization, provide information as to whether or not the claimed services have been specifically approved on a corresponding TAR; and

15) Maintain on the database Adjudicated Claims History for all claims for thirty-six (36) months and all other claims required for use and detection of services that are once in a lifetime or are needed to review service limitations of that history, as required by or in accordance with Department policy, guidelines, and CD-MMIS documentation. History over thirty-six (36) months old and not needed for history audits may be purged from the database and maintained on computer tape for beneficiary CDRs and for retrieval of other record requests.

4.3 ASSUMPTIONS AND CONSTRAINTS

The files and tables contained in the Reference File Subsystem significantly influence the number of services and total dollars paid under the program. It is imperative that the Contractor maintain stringent controls, including an ongoing audit trail, add, delete, and change transactions to all files; balance and control the updating of history records; and implement/maintain strict security controls to prevent unauthorized transactions or overrides of records or tables.

4.4 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Generate all Reference File Subsystem reports, files, and tapes produced by the Medi-Cal Dental Program. Reports, files, and tapes must meet the requirements described in the General Reporting Requirements Subsection, unless otherwise specified by the Contracting Officer. Reports, files

and tapes are to be produced in a manner compatible with and capable of being integrated into the CD-MMIS data in accordance with Department requirements; and

2) Actively participate in the Department's Policy Advisory Group (PAG) to resolve claim/TAR adjudication problems and to address changes in dental technologies within the Claims Processing Subsystem. Problem resolution may occur through development of or revision to program policies, as well as proposing new and/or modified edits/audits, etc. that are necessary to adjudicate claims/TARs in an accurate and consistent manner.

4.4.1 EDITS AND AUDITS CRITERIA

The Contractor shall:

1) Change the status (ON/OFF/TEST/OBSOLETE) of any edit or audit within twenty-four (24) hours of the Department's written direction;

2) Produce a listing, after each day of claims processing, indicating by edit/audit number all edits and audits which were active or inactive during that cycle. Edits and audits shall be modified at the "end" of a daily claims processing cycle, never "during" a daily claims processing cycle. The Contractor shall provide the listings to the Department within one (1) State workday of production;

3) Ensure prepayment controls, cycle times, and other program requirements are met;

4) Maintain edit and audit criteria including error parameter tables and combination audit tables, which shall be approved by the Department prior to implementation;

5) Maintain an edit and audit criteria table that is independent of program code to permit simplified access for review or revision;

6) Produce and deliver listings of edit and audit criteria tables to the Department no later than one (1) State workday after receipt of notification requesting such listing from the Department or upon modification of the criteria tables;

7) Ensure adherence to Title 22, California Code of Regulations and the Department's policies regarding scope of covered dental benefits and prior authorization requirements;

8) Ensure that the Contractor's Chief Dental Consultant or their designated representative serves on the Department's PAG. Other Contractor staff with relevant knowledge, skills, and qualifications, may attend PAG meetings dependent on meeting agendas. The Contractor shall not rely on the informal decisions reached at PAG meetings since all resulting decisions and/or directions will be communicated, in writing, to the Contractor by the Department (e.g., in the form of Dental Operating Instruction Letters (DOILs), Fiscal Intermediary (FI) Letters, System Development Notices (SDNs), Miscellaneous Change Documents (MCDs), Changes Orders, Problem Statement, etc.); and

9) Be aware of all requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and ensure that these requirements are considered in the development of any system change. The Contractor shall immediately notify the Department if, at any time, it is determined that a change resulting from a DOIL, FI Letter, MCD, or SDN will not be HIPAA compliant. The Department will then provide direction to the Contractor.

4.4.2 PROCEDURES AND PRICING FILE

The Contractor shall:

1) Maintain the Procedures and Pricing File and the corresponding Table Maintenance Procedures Manual for the life of the contract;

2) Maintain a cross-reference system of procedure coding schemes for purposes including, but not limited to, claim/TAR and authorization processing, and report generation;

3) Maintain records of valid procedures and acceptable beneficiary age matches for each procedure and information history cross-checks;

4) Implement additions, deletions, or changes to the Procedures and Pricing File within five (5) calendar days of receipt of notification from the Department unless otherwise instructed by the Contracting Officer. The Contractor shall edit the update transactions, produce, and deliver, error listings and transaction reports to the Department within one (1) State workday of all changes;

5) Maintain current and historical pricing and benefits information by procedure code with an effective date specific for each pricing period covered. Allowable benefits shall be

in accordance with Department regulations and policy. Previous pricing segments shall be retained on the file for the duration of this contract;

6) Utilize Department approved indicators on files to identify potential TPL cases;

7) Maintain in the Procedures and Pricing File, a narrative description of each procedure code contained in the files;

8) Maintain by date the audit trails of all updates to the Procedures and Pricing File. This audit trail shall be provided within one (1) State workday of the Department's request; and

9) Maintain the Reference File Subsystem to accept, process, and pay or deny billing codes subject to frequency counts. Frequency counts shall be used for provider billing codes as specified in Department supplied documentation and in DOILs.

4.4.3 ADJUDICATED CLAIMS HISTORY

The Contractor shall:

1) Ensure the Adjudicated Claims History File maintains claims history to permit the module to serve as a working historical database for use in S/URS and MARS, for duplicate and other history-related audits, and when responding to Department, beneficiary, or provider claim inquiries;

2) Ensure the Adjudicated Claims History file is updated by the start of each workday to reflect on-line transactions and transactions updated on a nightly basis. Ensure the system can detect simultaneously submitted claim/TARs and/or duplicated claim/TARs. Within one (1) State workday review CD-MMIS reports to verify that there are no duplicate claim/TARs submitted on the same day for the same beneficiary. All identified discrepancies shall be researched and resolved within the same State workday;

3) Accomplish updates and adjustments to history files used in claims processing by adding to or changing history and maintaining records of prior transactions as they occur;

4) Adjust the Adjudicated Claims History File for each provider and beneficiary to reflect retroactive rate changes within five (5) State workdays of written notification from the Contracting Officer. Those claims in suspense, which have been priced, shall be adjusted to reflect the rate change;

5) Retain all patient history for use in duplicate history and other prepayment audits as well as for use in the S/URS and MARS Subsystems. Purge criteria shall require that all history be maintained for thirty-six (36) months. The Department shall have on-line access to the database for "read only" purposes;

6) Maintain patient history indefinitely for those procedures which, according to Department policy, may be performed only once per beneficiary; once per beneficiary for the same provider; or are subject to frequency restrictions or benefit limitations. Utilizing beneficiary MEDS-ID number, ensure that all beneficiary claims history for a given beneficiary are linked, despite Medi-Cal ID number changes that may occur over time;

7) Utilize Adjudicated Claims History in conjunction with the Pended Claims History File to produce an on-line report summarizing a specific provider's claims pending data within the system and claims submitted by the provider;

8) Maintain an on-line file to which the Department shall have on-line access that will detail all information stored on the database for paid, denied, and adjusted claims by 8:00 a.m. PST the morning of the first (1st) State workday following the file update;

9) Summarize and report, as required by the Department, history file updates to ensure that records are updated accurately and that totals balance;

10) Incorporate any adjustments, retroactive recoveries and other appropriate actions that will add, void, or change claim history as files are updated; and

11) Maintain a seventy-two (72) month Claim History File(s) to be used in the production of recipient claim detail and aged history reports, and a thirty-six (36) month file for provider reports. These files shall be used for the processing of claims older than thirty-six (36) months including any returned provider checks or CIFs, and for use in erroneous payment correction. These files shall be updated monthly by the fifth (5th) calendar day of the month following the reporting period. Data from these files shall be archived and retained by the Contractor in accordance with Exhibit A, Attachment II, Operations, Records Retention Requirements Section for off-site storage following the seventy-two (72) month, or thirty-six (36) month respectfully, of its retention. Claims for one-time-only procedures or those procedures held on the thirty-six (36) month Adjudicated Claims History

database beyond the thirty-six (36) month interval due to frequency restrictions or benefit limitations or State policy, shall also be copied and included in the seventy-two (72) month Beneficiary History File.

4.4.4 PENDED CLAIMS

The Contractor shall:

1) Maintain on-line access to the Pended Claim History (PCH) file which shall include all claims/TARS that are "in progress", including those claims suspended or awaiting check write. On-line access shall be made available to the Department;

2) Update the PCH file on an on-line real-time basis for database transactions no later than 7:30 a.m. PST the next business workday after any batch transaction that adds, changes, or deletes records from the file;

3) Utilize the PCH file to create monthly aging lists, trended inventory statistics, and other management reports for use by the Contractor and the Department in monitoring system performance;

4) Provide the Claims Processing Subsystem with the on-going ability to produce listings of claim transactions currently pended in the system;

5) Retain records of pended claims in the PCH file until each individual claim reaches final disposition and payment or denial is issued to the provider;

6) Produce an on-line file that will give the status, Data Control Center (DCC) location, and reason for suspension of a claim/TAR within the processing system;

7) Ensure that the Department and/or Contractor has access to suspended claims by either provider identification number or beneficiary identification number;

8) Within the Adjudication Claims History File, summarize the on-line report data by provider for claims pending within the system and claims paid to that provider during each calendar year;

9) Ensure updates to any element of on-line reports take place no later than 7:30 a.m. PST the next business workday for any batch transaction within the Claims Processing

Subsystem that will add, delete, or change any of the file contents or elements;

10) Produce a weekly pended claims aged inventory listing available for on-line viewing in summary form and sorted by provider number;

11) Maintain the data elements assigned by the Claims Processing Subsystem;

12) Maintain the PCH file to assist in controlling the Claims Processing Subsystem;

13) Identify the DCC to which a specific document has been routed for resolution or further processing;

14) Maintain the PCH file to provide the Claims Processing Subsystem with a database from which exception documents may be generated;

15) Provide the Claims Processing Subsystem and MARS with on-line summaries of provider claim activity for use in provider relations;

16) Produce monthly listings of claims pended because of a certain error condition. This report shall be produced utilizing error conditions specified by the Department. The Department will specify no more that twenty (20) error conditions a month; and

17) Provide information to MARS for production of reports specified by the subsystem, by extracting information from the PCH subfiles.

4.4.5 TREATMENT AUTHORIZATION REQUEST (TAR)

The Contractor shall:

1) Maintain on-line TAR information to which the Department shall have access, which includes all TARs that have undergone or are undergoing adjudication. Each TAR record shall contain all procedures requested, and for each procedure, an indication that the procedure was approved as requested, modified, pended, or disapproved. NOAs shall be edited to ensure that those procedures billed which required prior authorization were authorized;

2) When a Notice of Authorization (NOA) is processed, the TAR record shall be updated to indicate the procedure was completed. File updates shall not be made until the NOA

has been processed through the payment module where the NOA becomes an Adjudicated Claim Service Line (ACSL). When no authorization was given for a claim line item, which required prior authorization, the claim procedure line item shall be denied, unless otherwise permitted by regulations (e.g., emergency);

3) Maintain CD-MMIS TAR data elements for each TAR received by the Contractor;

4) Maintain on-line access to all TAR information for matching approved procedures with billed procedures on incoming NOAs. This on-line access shall be available to the Department;

5) Update on-line the TAR information with any transaction that changes the status of a TAR line. Maintain the capability to further update TARs, once in the system, based on additional information received;

6) Ensure that when NOAs are paid, the appropriate TAR records are updated to indicate that authorized services have been rendered. The claim service line requiring treatment authorization shall be matched with the corresponding TAR. The TAR record matching the NOA shall be updated as paid when a pended NOA is paid and converted to an ACSL;

7) Maintain monthly aging reports, for TARs not yet adjudicated and for all TARs, trended inventory statistics, and other management reports for use by the Contractor and Department in monitoring performance;

8) Establish and maintain internal control over TARs and attachments from time of receipt through all aspects of processing. Such control shall continue until TAR adjudication, approval/denial, or modification has been completed, and the NOA has been released to the provider;

9) Provide a tracking mechanism and consequent visual display and reporting, to rapidly identify the status of a TAR during its processing, until provider notification is sent;

10) Maintain the existing Resubmission Turnaround Document (RTD) processes to request additional information and/or data from the dental provider for TARs pending further processing without returning the TAR and attachments to the provider;

11) Ensure that TARs are processed by document but approved/ modified/denied on a line item basis. The status (approved,

approved with modification, pended, or denied) of all TAR line items associated with a TAR document shall be maintained on a total TAR basis and be available on-line. Final notification to the provider, including the dates during which an approved TAR shall be active, shall not be sent until final determination had been made on all TAR/NOA line items; and

12) Maintain the current processing for purged TARs in accordance with the Claims Processing Subsystem, Exhibit A, Attachment II, Operations, TAR Purge Requirement.

4.4.6 INTERFACE WITH OTHER SUBSYSTEMS

The Contractor shall operate the Reference File Subsystem to maintain the data files for the S/URS, MARS, and Claims Processing Subsystems.

4.5 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Approve all modifications to the Reference File Subsystem prior to modification implementation;

2) Retain all review and approval rights to the use and processing of the Procedure and Pricing module, Adjudicated Claims History module, Pended Claims module, Edit and Audit Criteria module, TAR module, as well as plans, reports and data elements;

3) Provide the Contractor with procedure codes and modifiers that are acceptable or unacceptable under the Medi-Cal Dental Program;

4) Approve the status (ON/OFF/TEST/OBSOLETE) of all edits and audits;

5) Provide the Contractor with periodic updates to the edit and audit criteria for the table revisions;

6) Approve all new edits and audits or modifications to existing edits and audits;

7) Direct the Contractor to create new or revised edits and audits;

8) Develop all Medi-Cal dental policy for use by the Contractor in adjudicating claims;

9) Provide the Contractor with the Medi-Cal dental SMA and dental procedure codes; and

10) Notify the Contractor (i.e. FI Letters, DOILs, SDNs, Changes Orders, Problem Statement, etc.) of any additions, deletions. or changes to the Procedure and Pricing File.

5.0 CLAIMS PROCESSING SUBSYSTEM

5.1 OVERVIEW

The Claims Processing Subsystem is an integrated manual and automated system to process TARs and claims received from Medi-Cal dental providers as well as dental providers of the Children's Treatment Program (CTP), Healthy Families Program, County Medical Services Program (CMSP), Child Health and Disability Prevention (CHDP) Gateway, California Children's Services Program (CCS), and the Genetically Handicapped Persons Program (GHPP).

In this subsystem TARs are approved as submitted, approved as modified, or denied. The only exception is a Notice of Authorization (NOA) that has been returned by the provider requesting reconsideration of previously denied or modified lines. These requests may be referred to as TAR re-evaluations. The TAR re-evaluations may have been preceded by a Resubmission Turnaround Document (RTD) resulting in a NOA being issued.

The provider may submit a claim for services as a request for payment in two (2) methods: submission of a standard claim form or return of a NOA. Both can be submitted on standard forms or via Electronic Data Interchange (EDI). NOAs and claims for payment are either approved as submitted or approved as modified and prepared for payment, or denied. Like TARs, these three (3) actions may have been preceded by an RTD.

The Claims Processing Subsystem is central to all functions of the CD-MMIS and interfaces with all other subsystems.

5.2 OBJECTIVES

The Claims Processing Subsystem has specific objectives designed to reflect the intent of the subsystem and to meet State and federal requirements. These objectives are:

1) Ensure that all input is accurately captured timely and that positive control is maintained throughout processing;

2) Verify that the provider is an enrolled Medi-Cal dental provider and the beneficiary is eligible for services billed and/or authorized;

3) Adjudicate all claims/NOAs and ensure that timely payment to providers is in accordance with program policy and procedures, established reimbursement rates, and State/federal statutes and regulations;

4) Process TARs for approval, modification or denial in accordance with program policy and procedures, State, and federal statutes and regulations;

5) Ensure that checks issued to providers for payment of approved services are generated weekly along with the corresponding Explanation of Benefits (EOB);

6) Ensure that reimbursements to providers are rendered promptly and correctly;

7) Assist the S/URS to detect overutilization, underutilization, and potential abusers of the Medi-Cal Dental Program; and

8) Maintain CD-MMIS certification and all data necessary to meet the needs of other subsystems; satisfy legal requirements; and maintain required audit trails.

5.3 ASSUMPTIONS AND CONSTRAINTS

The Claims Processing Subsystem is subject to the following assumptions and constraints:

1) Provider and beneficiary data in the PMF, FAME, and all supporting files accessed by the Claims Processing Subsystem will be accurate and timely;

2) Providers, including out-of-state providers, must submit all requests for authorization of services, inquiries, and claims on Department approved forms. If using electronic media documents, they must be in accordance with Department approved format and specifications;

3) Application of the whole document concept is applied in the processing and payment of claims/NOAs/TARs. Each document is processed as a whole; however, each service line is reviewed and adjudicated separately;

4) Eligibility verification for claims processing shall reference against the Department's FAME file and information associated with the Eligibility Verification Confirmation (EVC) number;

5) In instances where the EVC number is in conflict with the Department's FAME file, the claim/NOA/CIF shall be adjudicated based on the EVC. In other words, if the FAME file indicates no eligibility but the EVC number provided on the claim/NOA/CIF indicates eligibility, the document will be adjudicated based on the EVC; and

6) All electronic media documents shall comply with the EDI standards adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and in accordance with Department approved formats and specifications.

5.4 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Generate all Claims Processing Subsystem reports produced by the CD-MMIS. Reports must meet requirements described in Exhibit A, Attachment II, Operations, General Reporting Requirements, unless otherwise specified in this section; and

2) Track, record and report all activity for each claim/NOA or TAR from receipt through final adjudication to include the update to the adjudicated claim history files. This tracking includes the identification of all RTDs, Share of Cost MC177 facsimiles, appeals, CIFs or any adjustments related to each claim/NOA or TAR. This shall include the documentation of each Data Control Center (DCC) location and date as the document moves through the system. This tracking system shall also provide a history of all edits and audits where the document has failed.

   All activities must be reflected on appropriate CD-MMIS reports with each Document Control Number (DCN), Most Recent Document Control Number (MRDCN), Correspondence Reference Number (CRN) or other identifying number and each DCC location with date of DCC entry to ensure a complete audit trail and to meet all reporting requirements.

5.4.1 DOCUMENT MANAGEMENT RESPONSIBILITIES

The Contractor shall:

1) Accept and accurately process all documents including claims, TARs, NOAs, RTDs, CIFs, Share of Cost-MC177 facsimiles, appeals, provider correspondence, radiographs, all supporting attachments, and other documents as specified by the Contracting Officer.

   Claims/NOAs/TARs/CIFs/RTDs may be submitted by hard copy or via EDI;

2) Perform manual prescreening functions, as directed by the Department prior to entry of claim/NOA/TAR/RTD/CIF data into the system. Examples of this manual review activity are screening incoming hard copy documents for the presence of:

   a) Attachments and radiographs (reproductions may be required by the Department);

   b) Proof of eligibility (when attached to the document);

   c) Valid (written) provider signature or initials or those of the provider's authorized representative. Signature stamps are not acceptable;

   d) Provider's address on radiograph envelopes;

   e) The Explanation of Benefits (EOB);

   f) Multipage documents; and

   g) Valid Remittance Advice (RA), Explanation of Benefits (EOB), or denial of service letter when beneficiary has other health insurance coverage.

      NOTE: The Document Management Manual and Processing Team Manual provide detailed manual screening procedures.

3) Scan the documents with optical character recognition (OCR) and intelligent character recognition (ICR) processing. At the time of scanning, the required field data from form documents are converted into a digital format to meet the data accessibility processing requirements for the Claim Processing Subsystem of CD-MMIS;

4) Capture, correct and validate all required fields of the form documents to include Claims, TARs, CIFs returned RTDs, and NOAs to an electronic format;

5) Re-key character(s) in required fields of the form documents that do not meet the document field(s) validation rules or OCR/ICR substitution errors;

6) Re-scan or key data enter all document images that are unreadable;

7) Provide an automated indexing system to be able to identify the retrieval location of an original document and all supporting documentation to which a decision could be determined to further adjudicate document. This will include

the capability of retrieval by Document Control Number (DCN), or referenced number assigned to radiographs or attachments;

8) Assign a unique DCN, CRN, MRDCN or other identifying number, as appropriate, to each claim, TAR, NOA, RTD, CIF, MC177 facsimile, appeal, and all supporting attachments indicating date of receipt. The date of receipt requirement applies to all documents. All attachments, including radiographs, must receive the primary document number to ensure a complete record can be retrieved;

9) Microfilm each document and any supporting attachments following assignment of the appropriate control number. Microfilm must be processed daily and a review performed to ensure that the microfilm meets the standards specified in Exhibit A, Attachment II, Operations, Data Processing and Documentation Responsibilities. The Contractor shall refilm any document(s) failing to meet the following standards prior to storage:

   a) Radiographs are not microfilmed but shall be reproduced upon direction from the Department or Contractor;

   b) Original documents and microfilm shall be retained as specified in Exhibit A, Attachment II, Operations, Record Retention Requirements section; and

   c) Upon the implementation of ICR and OCR, microfilm will become obsolete.

10) Enter data into the system from the documents received; perform all CD-MMIS claim/NOA/TAR data entry edits; verify data fields as specified in the Suspense and Error/File Maintenance Processing Manual; and post the receipt of EDI-related radiographs and attachments; and

11) Assign and maintain DCCs for all operational areas of front end processing for hard copy and electronic media documents such as EDI.

5.4.2 ELECTRONIC DATA INTERCHANGE (EDI) DOCUMENT RESPONSIBILITIES

The Contractor shall process EDI claims/NOAs/TARs and RTDs with the capability to link the EDI record to the radiographs or attach supporting documents received in the mail. The Contractor shall receive and process EDI documents according to the

submission procedures detailed in the EDI Specification and Protocol Manual and in accordance with the requirements below.

1) Ensure that providers and their duly authorized agents wishing to submit claims/TARs/NOAs on electronic media follow all required approval procedures and meet federal and State regulation standards for electronic billing;

2) Ensure that providers and their duly authorized agents are identified and approved by the Contractor prior to electronic media billing. The approval process shall meet State regulation standards for electronic billing;

3) Ensure that each provider and their duly authorized agent completes a Department approved EDI enrollment form before testing begins. The form must contain provider statements of certification and understanding that satisfy Federal and State requirements;

4) Ensure that EDI media document billings meet the Department and contractual requirements established for electronic billings. No other billing arrangement where the Contractor receives claims on an electronic basis is allowed;

5) Support EDI submission and retrieval twenty-four (24) hours each day Monday through Saturday;

6) Perform preliminary processing, to validate the number for total lines or claims and total dollar amount billed;

7) Verify that the EDI document contains all mandatory data elements and that it is in the correct format as part of the preliminary processing;

8) Accept for processing all EDI documents that pass the preliminary checks;

9) As a first (1st) step in processing, assign a DCN, or MRDCN, to each claim/NOA/TAR/RTD submitted via EDI. The DCN assigned to each claim/TAR submitted via EDI must be the same DCN assigned to the corresponding attached documents. The DCNs/MRDCNs must be assigned by the Contractor in accordance with date of EDI receipt. (EDI and paper claims/NOAs/TARs/RTDs are to be identified through assignment of a special number in the DCN/MRDCN/CRN). The Contractor shall also generate a computer output microfilm (COM) and/or electronic media copy of each claim/NOA/TAR/RTD document submitted via EDI and a microfilm copy of each attachment (except radiographs) received through the mail. The system must carry the COM of the EDI claim/NOA/TAR/RTD and the microfilm copy of

the attachment(s) (except radiographs) together, and have all easily retrievable through the use of the assigned DCN/MRDCN. These COM and microfilm/scanned copies must be reformatted to look similar to paper documents when viewed on microfilm terminal. The microfilm/scanned copies must be retained, by the Contractor as required in Exhibit A, Attachment II, Operations, Records Retention and the Expert Witness sections;

10) Enter the documents into the normal processing system after assignment of the DCN/MRDCN;

11) Return electronic acknowledgment to the provider that reports the number of claims received, which claims were accepted or rejected and why certain claims were rejected (e.g. missing information);

12) The Contractor shall utilize procedures that ensure that all attachments and/or radiographs are for the correct claim/TAR/NOA/RTD entered into the system via EDI (i.e., same beneficiary, provider and service office);

13) Ensure that upon adjudication the radiographs are returned to the provider within eight (8) State workdays. The radiographs will be recycled in the event the provider does not want the radiographs returned;

14) Make available electronic media EOB for providers if requested;

15) Provide reports for electronic retrieval by providers. These reports are defined in the EDI Specification and Protocol Manual;

16) Provide identification labels and specially marked envelopes to providers for mailing additional information (e.g., radiographs or other documentation) in support of EDI documents; and

17) Establish and maintain an EDI Support Group with responsibilities in:

    a) Pre-enrollment Assistance

    b) Technical Support

    c) EDI Testing Certification

    d) EDI Information Maintenance

    e) Production EDI Help Desk Support

5.4.3 CLAIM/TAR ADJUDICATION RESPONSIBILITIES

The Contractor shall:

1) Maintain and apply Department approved CD-MMIS prepayment/pre-authorization edits and audits to verify accuracy and validity of claim/NOA/TAR/CIF data for proper adjudication. The CD-MMIS edits/audits may be categorized as:

   a) Claim/NOA/TAR Data Entry Edits

   b) Provider Edits

   c) Recipient Edits

   d) Procedure Edits

   e) History Cross Check Audits

2) Verify that all beneficiaries for whom claims/NOAs are submitted qualify to receive benefits that will be reimbursed through the CD-MMIS. This verification must substantiate that the beneficiary was eligible for the service on the day it was performed and has no eligibility limitations, (e.g., member of a prepaid health plan which covers dental services); beneficiary restricted to coverage provided under the CMSP; has other insurance coverage; has not met the Share-of-Cost; or is on restricted status for the services with no prior approval document, etc., which would preclude or affect payment.

   Eligibility verification during claim adjudication under the current CD-MMIS is accomplished by matching data on claims/NOAs with data on the FAME file. If a valid match cannot verify eligibility, the Contractor shall review for the presence and validity of one (1) of the following Department-sanctioned proofs of eligibility:

   a) Original or copy of Department-generated or County-generated non-restricted or restricted proof of eligibility label;

   b) AEVS verification number (i.e. EVC number) listed in the remarks data field on the claim form that shall be verified through a match with the AEVS record; and

   c) Other forms of proof of eligibility as defined by the Department.

If eligibility cannot be verified by a valid match with the FAME file and one (1) of the above proofs of eligibility is not present, the claim/NOA shall be held in suspense for five (5) State workdays. At the end of that time, a second attempt is made to verify eligibility. If eligibility cannot be established via the FAME transaction and no EVC record is found, the claim/NOA shall be RTD'd. (Refer to the Suspense and Error/ File Maintenance Processing Manual.)

NOTE: Medi-Cal eligibility, not month of eligibility, is verified for TARs as service(s) requested is/are in the future. If the TAR document indicates eligibility pending, then a beneficiary record is created using the SSN number and/or Beneficiary Identification number on the TAR. However, if no beneficiary eligibility is found via FAME, or EVC number is not present, generate an RTD. (Refer to the Suspense and Error/File Maintenance Processing Manual.);

3) Utilize recipient ID cross-reference data to maintain continuous beneficiary claims history, despite beneficiary ID number changes;

4) Verify that the billing provider and/or rendering provider are an enrolled Medi-Cal dental provider;

The PMF must be accessed and a determination made that the provider is eligible to perform the services requested and/or was eligible to receive reimbursement for the billed service on the date of service. Any individual provider related restriction such as special claims review, payment withholds, including withholds for delinquent taxes, or other limitations must be applied as instructed by the Department.

For in-state and border provider groups, in accordance with existing CD-MMIS design, if the billing provider did not perform all services billed, enrollment and eligibility of the rendering provider must meet the same requirements as those stated above.

A claim shall not automatically be RTD'd or denied if the billing provider number is incorrect or missing. The Contractor shall research the provider number on file and correct if possible. If a match is not found, the Contractor shall deny the claim with a message that the provider number is incorrect or missing.

Payment for services rendered by an ineligible dental provider shall be denied;

5) Maintain ability to modify processing procedures to adjudicate special claim categories as operational in CD-MMIS or as directed by the Contracting Officer;

6) Process specific claims, either manually or through the system (e.g.,court ordered payments, special billing waivers, fair hearing decisions etc.), as directed by the Department. This processing requirement applies to previously adjudicated claims. Processing instructions and requirements for payment will be provided by the Contracting Officer. These claims shall not be automatically denied due to changes in edits and/or audits implemented subsequent to the processing of the original document. These claims shall be processed within ten (10) State workdays or as directed by the Contracting Officer;

7) Adjudicate claims/NOAs/TARs in accordance with all Medi-Cal Dental Program policy and procedures as reflected in California statutes; the Manual of Criteria for Medi-Cal Authorization (Dental Services); Title 22, California Code of Regulations (CCR); DOILs; policy of specialized programs which include CTP, Healthy Families, CMSP, CHDP Gateway, CCS, GHPP, and Department approved manuals or directives, to verify prior to approval of payment that the service(s) requested or billed is/are valid; e.g.:

   a) A covered Medi-Cal dental benefit;

   b) Authorized in advance, if required, and that all critical claim/NOA data agree with the critical TAR data as described in TAR processing;

   c) Consistent with the diagnosis reported or the age and/or sex of the beneficiary; and

   d) Not a duplicate of a service previously paid.

8) Not exceed approved service limits. Welfare and Institutions Code, Section 14115, and Title 22, CCR, 51008 and 51008.5, stipulate that bills for service shall be received no later than the sixth (6^{th}) month following the month of service for full payment, except for good cause, and that where a delay in the submission of bills was caused by circumstances beyond the control of the provider, the period for the submission of bills can be extended up to but cannot exceed one (1) year after the month of rendered service;

9) Provide the capability to override a specific edit or audit as directed in writing by the Department. The Contractor shall not override any edit or audit without specific prior written approval from the Department. Further, if the Department

approved edit/audit criteria requires manual review prior to override, the Contractor shall not, without the approval of the Contracting Officer, use automated processing methods to perform the override.

Reports reflecting override activity, as currently generated by CD-MMIS, shall be produced according to the requirements contained within the General Reporting Requirements section;

10) Maintain the ability to modify dental procedure codes as directed and approved by the Department. [This process is called Replace and Substitute (R&S)];

11) Retain the three (3), four (4), and five (5) digit dental procedure code scheme. These procedure codes are identified in the Manual of Criteria for Medi-Cal Authorization (Dental Services);

12) Maintain and utilize Department approved CD-MMIS DCCs to house claims/NOAs/TARs and specifically define suspense locations. All DCCs used for claim/NOA/TAR processing shall have a name; however, this will not preclude the Contractor from establishing DCCs for special processing, as approved by the Department. All Contractor elected DCC changes shall be submitted to the Department for review and approval prior to implementation. The Contractor shall implement DCC changes upon request/approval of the Contracting Officer. DCC specifications shall be included in the System Detail Design;

13) Process specific claims/NOAs/TARs, or claims/NOAs/TARs in specific DCCs already in the system or new documents, on a priority basis as defined by the Contracting Officer, either manually or through the system. Documents to be processed could be selected out of suspense, or a group of documents, for a specific provider, which have not yet been entered into the system and must begin with front-end processing. This processing requirement applies to unadjudicated claims/NOAs/TARs. Department directed priority-processing requests will not exceed thirty (30) requests per month for individuals or groups of providers, or a total of one thousand (1,000) claims/TARs/NOAs per month. Priority process claims/TARs/NOAs within five (5) State workdays of receipt of request as directed by the Contracting Officer.

Upon Department approval, suspend selected claims in the unique priority processing DCC. If the Contractor caused the error/problem, the time in the unique DCC is included in cycle time calculations. If the error/problem is Department

caused, the time in the unique DCC is excluded from cycle time calculations.

The Contractor shall use the priority processing select program to identify claims/NOAs/TARs/RTDs for priority processing.

The Contractor shall return priority processing request forms to the Department within two (2) State workdays of completion of the priority-processing request documenting date of completion;

14) Review CD-MMIS edits/audits to determine any that are appropriate to modify in order to ease provider billing requirements. The Contractor shall follow the edit/audit survey requirements as specified. The Contractor shall implement all modifications to CD-MMIS edits as approved by the Department;

15) Place Contractor-controlled claims/NOAs identified as remaining in the system longer than ninety (90) calendar days, and TARs remaining in the system over sixty (60) calendar days, in unique DCCs and expeditiously adjudicate them. Report such information to the Department as specified in the Quality Management Section;

16) Suspend into a unique DCC, claims/NOAs/TARs that are being affected by a claim/NOA/TAR processing problem/error that has been identified by the Department or the Contractor. Claims/NOAs/TARs shall only be suspended into this unique DCC upon Department approval. The Contractor shall use the priority processing select program to identify all affected claims/NOAs/TARs. The time that claims/NOAs/TARS are in the unique DCC is excluded from cycle time calculations if the problem/error is Department caused. If it is Contractor caused, the time shall be included in the cycle time calculation. After correction of the identified problem(s), all documents suspended for those reasons shall be released into the claims processing system to complete processing;

17) Generate a letter of notification to beneficiaries and/or their authorized representative(s) when services requiring prior authorization have been modified or denied. The Contractor shall, through the Beneficiary Services Operation, provide assistance to inquiries resulting from such notification (see Exhibit A, Attachment II, Operations, Beneficiary Services);

18) Process all TAR reevaluations which include returned NOAs requesting reconsideration of previously denied requested services in accordance with the processing time

requirements stipulated in TAR Processing Cycle Time Requirements; and

19) Apply CD-MMIS requirements/procedures to claims/NOAs/TARs for out-of-state providers as mandated in Title 22, CCR Code, Section 51006. NOTE: Out-of-state provider groups are exempted from the requirement to submit a rendering provider number on their claims when the service is performed by other than the billing provider.

Border providers are identified on the PMF and are subject to all requirement/procedures applied to in-state providers.

5.4.4 ADJUDICATE CLAIMS/NOTICES OF ACTION (NOAs)

1) Automated adjudication of claims/NOAs.

a) NOAs returned for payment without changes to the original authorized treatment and are for procedures that do not require NOA review are processed automatically; and

b) Claims/NOAs that successfully pass all edits and audits are forwarded to the payment module for final adjudication. Claims/NOAs that fail any edits and/or audits require suspense processing for resolution of those edits or audits which failed.

2) Automated Adjudication of claims/NOAs with manual intervention.

Claims for services and NOAs that require the manual review of radiographs or documentation shall be system edited, for basic information and data validity including but not limited to: provider eligibility, beneficiary eligibility, procedure code validity and the presence of required data. Following this initial editing, claims/NOAs and attached radiographs or documentation will be subjected to the manual review process.

During the manual review process, dental consultants and dental paraprofessionals shall review the diagnostic material presented and the procedures listed on the claim/NOA to determine that the services were necessary and in accordance with Medi-Cal dental policy and procedures or for NOAs completed as approved. Paraprofessionals are allowed to approve services based on the documentation submitted. However, if the paraprofessional cannot determine that the service is a benefit of the program or is medically necessary, the document shall be reviewed by a

dental consultant. Only a dental consultant can modify or deny a claim service line (CSL) on the basis of medical necessity.

NOTE: If the Contractor prepares and distributes Exceptional Processing Instructions (EPIs) for use by staff in the processing of documents, each EPI shall include a start/end date and shall be submitted to the Department for review and approval prior to distribution and implementation. EPIs shall only be used to communicate time-critical processing instructions to adjudication staff, in which immediate implementation is deemed necessary by the Department. An EPI shall expire no later than thirty (30) days from the date of issuance;

3) Because of prior review as a TAR, returned NOAs do not go through the full edit process. Only new fields are edited. Most NOAs upon return can be auto-adjudicated with a minimum of manual intervention. However, the Manual of Criteria for Medi-Cal Authorization (Dental Services) requires some NOAs to be subject to professional/paraprofessional review upon their return; and

4) The Contractor shall control radiographs to ensure that they are retained until all affected CSLs associated with a claim/NOA document have been adjudicated. The Contractor shall return the radiographs to the provider within eight (8) State workdays after final adjudication. The radiographs will be recycled in the event the provider does not want the radiographs returned.

5.4.5 TREATMENT AUTHORIZATION REQUEST (TAR) PROCESSING

The Contractor shall perform prior authorization for treatment in accordance with Medi-Cal dental policy and procedures when prior authorization is required by Title 22, CCR, Section 51307.

As part of the ongoing quality of care review and evaluation, selected providers may be required to obtain prior authorization for some or all services, except those exempted by Title 22, CCR, Section 51455.

1) All out-of-state services require prior authorization except:

   a) Emergency services as defined in Title 22, CCR, Section 51056(a); and

   b) Services provided in border areas adjacent to California where it is customary practice for California

residents to avail themselves of such services. Under these circumstances, Medi-Cal and CCS program controls and limitations are the same as for services from providers within the state. No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

2) Necessary out-of-state dental care, within the limits of the program is covered only under the following conditions:

   a) When an emergency arises from an accident, injury, or illness;

   b) Where the health of the individual would be endangered if care and services are postponed until it is feasible that the individual return to California; or

   c) Where the health of the individual would be endangered if the individual undertook travel to return to California.

3) TARs shall be system edited for basic information, service limitations, provider eligibility, etc. TARs that fail the edits shall suspend for review and when applicable, requests for additional information from the providers are to be generated. The request for additional information shall be via the RTD;

4) Paraprofessionals and, if necessary, dental consultants shall review TARs. Dental paraprofessionals are allowed to authorize services based upon the documentation submitted. However, if the paraprofessional cannot determine that the service is a benefit of the program or is medically necessary, the TAR shall be forwarded to a dental consultant. Only a dental consultant can modify or deny TARs on the basis of medical necessity; and

5) NOAs are generated to inform the provider of the approval, denial, or modification of requested services. The provider must return the NOA and appropriate documentation when requesting payment for services rendered or when canceling all or part of the pre-authorized services. In addition, the Contractor shall generate a letter notifying the beneficiary and/or their authorized representative, as applicable, of those requested services that have been denied, or modified.

5.4.6 CLINICAL SCREENING OF TARS

1) Some TARs prior to approval, modification, or denial may require a screening or second opinion by a clinical screening dentist. A clinical screening dentist is a California licensed dentist utilized by the Contractor to review dental treatment proposed or performed by Medi-Cal dental providers;

2) When the findings of the clinical screening dentist conflict with the observations/diagnosis of the beneficiary's treating dentist, such screening reports shall be reevaluated/adjudicated by a Contractor-designated dental consultant;

3) Second opinion Clinical Screenings may also be utilized to evaluate appropriateness of:

   a) Beneficiary complaints;

   b) Previously denied services that subsequently result in the filing of fair hearing requests;

   c) Quality of care reviews; and

   d) S/URS related reviews.

4) Payment to the Contractor for the Clinical Screening process shall be part of the Contractor's fixed price for TARs;

5) The criteria for selecting procedures for Clinical Screening are identified in the Appendix of the Manual of Criteria for Medi-Cal Authorization (Dental Services). The Appendix states, in part, that clinical examinations shall not be routinely used to gather information that should be supplied by the provider;

6) In addition to those procedures, the Contractor shall:

   a) Screen all TARs involving non-immediate removable prosthetics when the documentation or radiographs do not justify the need for the requested services;

   b) Screen all TARs for beneficiaries residing in a State-licensed facility except for cases involving less than four (4) extractions or less than three (3) restorations;

   c) Control radiographs to ensure they are retained until all affected requested service lines have been adjudicated. The Contractor shall return all radiographs to the provider within eight (8) State workdays of final adjudication of the TAR. The radiographs will be recycled in the event the provider does not want the radiographs returned; and

d) Process TARs for medically necessary orthodontic services. These services shall be available to individuals with handicapping malocclusion up to the age of twenty-one (21). The Manual of Criteria for Medi-Cal Authorization (Dental Services) describes this program benefit.

5.4.7 THIRD PARTY LIABILITY RECOVERIES

The Contractor shall:

1) Process and identify claims/NOAs for beneficiaries with potential third (3rd) party dental coverage through application of specific Department approved edits and by accessing FAME for indicators of other insurance or other program coverage, or by using additional other coverage information provided to the Contractor by the Department. In cases where the Contractor or its parent entity may be the liable third (3rd) party, the Contractor shall not make payment under the Medi-Cal Dental Program until the third (3rd) party liability has been fully utilized or it has been determined that the third (3rd) party has no liability for the cost of services. In instances where the Contractor's third (3rd) party liability was not known at the time the Medi-Cal payment was made, the Contractor shall reimburse the Medi-Cal program to the extent of the Contractor's liability within ten (10) State workdays of discovery by the Contractor;

2) Make no claim for recovery of the value of covered services rendered to a beneficiary when such recovery would result from an action involving the tort liability of a third (3rd) party, casualty liability insurance, including Workers' Compensation awards and uninsured motorists coverage, or recovery from the estates of deceased beneficiaries. The Contractor shall not claim or be entitled to these third (3rd) party liability recoveries. The Department shall make these recoveries;

3) Identify and notify the Department within ten (10) State workdays of discovery of cases in which an action by a Medi-Cal beneficiary involving the tort or Workers' Compensation liability of a third (3rd) party could result in recovery by the beneficiary of funds to which the Department has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code;

4) Notify the Department in cases where the Medi-Cal beneficiary is age fifty-five (55) or older, or deceased. The Department may file a claim, pursuant to Welfare and

Institutions Code Section 14009.5. The Contractor shall refer such cases to the Department within 10 calendar days of discovery;

5) Identify cases where payment was made for certain prescribed trauma service codes and send out monthly questionnaires to identified beneficiaries to determine if a third (3rd) party is responsible for paying for dental treatment for the illness/injury. All completed questionnaires indicating that the beneficiary has filed or intends to file a claim or lawsuit and/or that insurance coverage is available to cover the recipient's dental expenses must be forwarded to the Department within ten (10) calendar days of discovery;

6) Submit monthly reports to the Contracting Officer for the following:

   a) Claims with an indicator of employment-related illness/injury; and

   b) Claims with an indicator of a tort-related illness/injury.

7) Ensure each report contains the following data items:

   a) Beneficiary name;

   b) Social Security Number;

   c) Date of birth;

   d) Contractor name;

   e) Provider name;

   f) Indicator of employment or tort-related illness/injury;

   g) Date(s) of service;

   h) Procedure code and/or description of services rendered;

   i) Amount billed; and

   j) Amount paid.

8) Identify to the Department the name, address, and telephone number of the person(s) responsible for receiving and complying with requests for service history information;

9) Direct any requests received from attorneys, insurers, or recipients for copies of claims and/or services data for a tort liability action, to the Contracting Officer or his/her designee;

10) Identify and report on the MR-O-350 all claims/NOAs for which services are potentially covered by other insurance;

11) Under Federal law, if the third (3rd) party coverage is known at the time that the claim is processed, ensure that the third (3rd) party benefits have been exhausted before Medi-Cal payment. The Contractor shall not pay claims for a beneficiary whose Medi-Cal eligibility record indicates third (3rd) party dental coverage without proof that the provider has first (1st) exhausted all benefits of the other liable party(ies). Proof of denial for prepaid dental coverage because said provider does not participate in the beneficiary's dental plan is unacceptable. Proof of denial of coverage because the provider did not meet the insurer's billing requirements (such as prior authorization or timely filing) is also unacceptable. Proof of third (3rd) party billing is not required for services provided to beneficiaries with OHC codes provided by the Department for payment of only the insurance co-payments;

12) If prepayment editing beyond that discussed above is not feasible, be responsible on a postpayment basis (except for Medicare or CHAMPUS or those beneficiaries identified as being in a dental health plan on the Department eligibility file) for identifying those coverage (commercial) sources which have an obligation to pay all or a portion of the dental care costs incurred by recipients. The Department uses the Medi-Cal Eligibility Data System (MEDS) to maintain information about the recipient's health or dental insurance and Medicare coverage. Health or dental coverage information is stored on the MEDS Health Insurance System (HIS) database. The HIS provides recipient specific OHC information, including policy effective dates, policyholder and scopes, or categories, of coverage.

    Insurance carrier/plan information is also maintained in the Health Insurance System (HIS). This information will be available to the Contractor. This information is also available to providers through the Department's AEVS;

13) Generate monthly reports to the Department displaying claim counts and dollar amounts of cost avoided. Reports are to designate counts and dollar amounts due to health insurance coverage, Medicare Part A, and Medicare Part B. The reports shall also include amount of all claims cost avoided or payments recovered when the Contractor, or its parent entity, is the liable third (3rd) party. If the Contractor

identifies dental coverage unknown to the Department, the Contractor shall report this information to the Department within ten (10) calendar days of discovery in an automated format as prescribed by the Department; and

14) Not encourage Medi-Cal recipients to drop any available private health or dental coverage.

5.4.8 SHARE-OF-COST (SOC)

The Contractor shall:

1) Process claims with a Share-of-Cost (SOC) obligation. Access the MC-177 Share of Cost Control number through CD-MMIS. The SOC adjudicator retrieves the MC-177 facsimiles manually for information to adjudicate claims/NOAs for beneficiaries identified by FAME as having potential SOC obligation;

2) MC-177 SOC information is created by CD-MMIS from the AEVS transactions log file, which is transmitted to CD-MMIS from the Medi-Cal Eligibility Verification/Claims Management System (CA-EV/CMS) on Tuesday through Saturday each week. This log file is also referred to as the EVCOI (Eligibility Verification - Other Intermediary) file. CD-MMIS automatically assigns the MC-177 SOC control number; and

3) Process each claim/NOA/CIF through the application of the edits and audits. Price approved claims/NOAs shall be processed as directed by the Department and as specified in the CD-MMIS detail design, policy Statements, and SOC Claims Procedures Manual.

5.4.9 RESUBMISSION TURNAROUND DOCUMENT (RTD) PROCESSING

The Contractor shall:

1) Issue RTDs when claim/NOA/TAR errors or omissions can only be corrected via changed or additional data from the billing provider. If the document can be corrected from data on the claim/NOA/TAR or CD-MMIS reference files, the Contractor shall correct that data. The RTD must supply the provider with all necessary information to research the original claim/NOA/TAR and resolve the error(s) cited. All RTDs generated for a provider during one (1) day's processing shall be mailed to the provider in the same envelope and shall be mailed within three (3) days to the provider's service location address. All RTDs mailed shall

be sorted to obtain the presort discount on first (1st) class mail and zip + 4 discount. The Contractor shall not establish any process or criteria to automatically issue a RTD without prior Department approval;

2) In the event, a RTD is returned from the provider and the information is insufficient to resolve the claim/NOA/TAR suspension:

   a) Deny the service(s) associated with the RTD and continue with the processing of the remaining services as appropriate;

   b) If the suspended CSL affects the entire claim/NOA, deny the entire claim/NOA and notify the provider of the reason(s) for complete denial via an EOB; and

   c) If the suspended CSL affects the entire TAR, deny the entire TAR and notify the provider of the reason(s) for complete denial via a NOA.

3) Deny the claim/NOA/TAR if the provider fails to respond to the RTD within forty-five (45) calendar days from the issuance of the RTD. Notification on the EOB for a denied claim/NOA, or on the NOA for a denied TAR, must specify lack of response to the RTD as the reason for denial. The Contractor must ensure the RTD has not been returned, (e.g., is not under Contractor's control, awaiting entry), prior to denial;

4) Manually review and adjudicate all claims/NOAs/TARs suspended for potential denial with the following exceptions that may be denied via the automated system:

   a) Claims without a provider response to a RTD after forty-five (45) calendar days;

   b) Claims submitted as electronic media documents in circumstances approved by the Contracting Officer; and

   c) Other conditions approved by the Contracting Officer.

5) Identify to the provider the reason(s) for the denial on the EOB when a claim/NOA is denied. The system shall generate a NOA to inform providers of such denials. They too shall include the unique denial code message. The auto denials for claims/NOAs/TARs must be captured and reported on the approved CD-MMIS reports.

5.4.10 CLAIM INQUIRY FORM (CIF)

The Contractor shall process and respond to all CIFs. All CIFs shall be acknowledged within five (5) calendar days of receipt. All CIF processing cycle time requirements are identified in Cycle Time Requirements within this section.

1) CIFs are categorized as follows:

   a) Tracer - The provider is seeking the status of a certain claim/NOA/TAR;

   b) Adjustment - The provider is seeking an adjustment to a previously paid claim/NOA; and

   c) Reevaluation - The provider is seeking re-consideration of a previously denied claim.

2) CIF processing requirements: Suspend, manually review, and correct CIFs for the following conditions:

   a) Key data entry errors;

   b) Pertinent information is provided on the CIF document but is incorrect or is found elsewhere in the submission as an attachment or in the remarks section, (e.g. clarification of previous claim error, correction of obvious errors such as beneficiary number or DCN). For example, if a claim was denied for failure to provide a correct beneficiary identification number and the provider submits the CIF with corrected information, the CIF shall be suspended to provide for correction and processing of the CIF;

   c) DCN information to access the related claim;

   d) In cases where a provider desires to return a payment to the Department or the Department directs a specific adjustment, the Contractor shall also adjust the claims history database. All adjustments must update claims history so as to be reflected on CDRs;

      In cases of an overpayment where no history is found, adjustments must be documented on a special report;

   e) CIFs shall be processed to meet the CIF cycle time requirements as specified in Provider Cycle Time Requirements;

f) Ensure that CIFs submitted by providers requesting an adjustment of a paid claim or reconsideration of a denial are submitted no later than six (6) months following the date of payment or denial of the claim, as specified in Title 22, CCR, Section 51008(d). (Overpayments are an exception to the six (6) month policy and are to be processed whenever they are received.) CIFs received after this time period shall be denied;

g) Accept provider personal checks regardless of the date of Medi-Cal payment and adjust history. If the date of the Medi-Cal payment is older than thirty-six (36) months, accept the money and report the data on the quarterly report(s); and

h) Offset payment when notified by a provider that an overpayment has occurred.

3) The Contractor shall return all radiographs to the provider within eight (8) State workdays of final adjudication of the CIF. The radiographs will be recycled in the event the provider does not want the radiographs returned; and

4) The Contractor shall provide on-line access to the CIF processing system (including suspended CIFs) for Department and Contractor staff.

5.4.11 CONTRACTOR REVIEW UNIT

The Contractor shall:

1) Maintain sufficient California licensed dental consultants and dental paraprofessional staff to assure accurate and timely resolution of supended claims/NOAs/TARs and CIFs to meet cycle time and inventory aging requirements;

2) Ensure that dental consultants and dental paraprofessionals review the diagnostic materials presented and the dental procedures requested or billed to determine if the services were covered benefits and medically necessary in accordance with Medi-Cal dental policy. Dental paraprofessionals cannot deny services based on lack of medical necessity;

3) Ensure a dental consultant shall manually price Medi-Cal dental covered services according to Medi-Cal dental policy, for which no price is available in the automated system or are billed as a by-report procedure. All manual pricing

procedures and methods shall be documented within the Professional/Paraprofessional Adjudication Manual (PPAM);

4) Ensure Medi-Cal dental policy, as determined by the Department, is consistently applied to all claims/NOAs/CIFs/TARs. Policy is interpreted through utilization of the Department-approved edits/audits. All Department approved processing requirements must be maintained in the Suspense and Error/File Maintenance Processing Manual and the Professional/Paraprofessional Adjudication Manual (PPAM) and all other related manual(s) to assure consistent policy application;

5) Ensure a close working relationship is maintained between the Contractor and the Department to resolve processing problems and to provide input in developing edits and audits in accordance with dental program policy and procedural requirements. A formalized component of this relationship is the requirement that the Contractor provide representatives to serve on the Dental Policy Advisory Group as described in Exhibit A, Attachment II, Operations, Reference File Subsystem;

6) Ensure a required function of professional review is Special Claims Review (SCR). This is a separate review designed to conduct manual review of claims from providers placed in SCR status by the Department. These providers have been referred by the Contractor and determined by the Department to be potential abusers of the Medi-Cal dental program and identified on the Provider Master File by the Contractor as being subjected to SCR. This manual review includes, but is not limited to, the determination of clinical quality and the medical necessity for the covered service prior to payment or authorization.

   The dental consultant staff shall be available to respond to SCR provider inquiries to explain Contractor action on specific claims; and

7) Refer to the Department and the Contractor's S/URS function within thirty (30) calendar days of detection, notice or inquiry, those providers who are identified by the Contractor as being potential abusers of the program. These providers may be identified through the review of claims suspended for manual review, through referrals, complaints or inquires received by the Contractor. The Contractor shall begin S/URS reviews of these providers as described in Exhibit A, Attachment II, Operations, Surveillance and Utilization Review Subsystem.

5.4.12 CLAIM PAYMENT RESPONSIBILITIES

The Contractor shall:

1) Process checkwrites, including producing checks and EOBs, on a weekly basis. Once a claim/NOA has been processed to full adjudication it shall be included in the checkwrite;

   NOTE: By the fifth (5th) State workday of each month, the Contractor shall submit to the Department magnetic tapes summarizing all payment activity during the previous month. (See Report Users Manual, MR-O-276 report for details);

2) Process, prepare, and maintain all checkwrite functions at the Sacramento facility, unless specifically exempted by the Contracting Officer;

3) Provide direct deposit of payment and electronic media EOB to providers requesting the services;

4) Notify the providers via the EOB of the status of any and all claims/NOAs that have been suspended in the system for eighteen (18) calendar days or more. The first (1st) notification shall occur on the EOB that immediately follows the eighteenth (18th) day of suspension and shall continue to be shown on the EOB until final adjudication is reached;

5) Resolve restrictions prior to payment, such as overpayments, improper payments, liens, and levies, and process all accounts receivable activity;

6) Daily provide all necessary data for maintenance of the adjudicated claim history file (ACHF);

7) Maintain and update the accounts receivable system as described in the Financial Management Manual;

8) Convert any negative balance(s) to an accounts receivable prior to the next checkwrite. A negative balance occurs as a result of adjustments, overpayment collections, etc., and when a provider's obligation to the Department exceeds the total payment due the provider for a given checkwrite. Upon establishment of the A/R, the Contractor shall initiate a 100 percent (100%) withhold against payment for claims, or the percentage of the payment that will clear the A/R. The Department may, at its discretion, alter the percentage of withhold against the provider's claims payment;

9) Process retroactive rate changes in accordance with Department-approved policies and procedures and as directed in DOILs;

10) Maintain records for and process interim payments. Interim payments are normally those payments made to providers for unpaid claims that have been in the system for thirty (30) calendar days or more due to Contractor or Department errors, or for paid claims affected by retroactive changes. The following interim payment procedures shall be followed:

    a) Providers may request interim payments in writing or by telephone (if by phone, the Contractor must subsequently follow-up in writing). Upon receipt, the Contractor shall log all requests by provider name, provider number, dollar amount of the request, and the date received (and the time if the request is by phone);

    b) If the Contractor determines that a provider does qualify for an interim payment, the Contractor shall approve and issue the payment and inform the Department of the interim payment. The Contractor shall deliver these findings to the Department within two (2) State workdays of its determination and at the same time notify the provider in writing of it decision;

    c) If the Contractor denies a request for interim payment, the Contractor shall forward to the Department such requests within seven (7) State workdays from the date the Contractor receives the provider's written request. The Department will review the Contractor's findings and make the final decision to approve or deny the interim payment request;

    d) When the Department disapproves a Contractor's decision to deny an interim payment, the Department shall verbally notify the Contractor and shall provide written confirmation to the Contractor, within two (2) State workdays. The Contractor shall then verbally notify the provider within twenty-four (24) hours of the Department's verbal notification and issue the interim payment and then follow-up the notice in writing within two State workdays.

    e) When the Department agrees with the Contractor's decision to deny, the Department will take no action; and

    f) Upon request, and within one (1) State workday of the request, the Contractor shall provide the Department with all records of provider request and subsequent

correspondence, including related accounts receivable records and status of the affected provider.

11) Produce hard copy and electronic EOBs including full narrative descriptions of all messages corresponding to printed EOB denial and/or adjustment codes;

12) Process provider grievances, e.g., appeals, in the manner and time frames prescribed in Title 22, CCR Code, Section 51015. This process shall also include the Contractor contacting the provider by telephone to solicit additional information such as documentation and/or radiographs in cases where the appeal is based upon medical necessity and is a covered benefit but the documentation/radiographs is/are insufficient to justify the services(s). The Contractor shall provide instructional information and/or materials requested by the provider to help them in their future efforts to submit complete and accurate claims;

13) Assist the Department in responding to dental fair hearings as described in Exhibit A, Attachment II, Operations, Beneficiary Services Subsystem;

14) Retain all one-time only or service limited procedure history records on the adjudicated claims history file;

15) Process provider initiated adjustments;

16) Acknowledge receipt of returned payment or provider check within five (5) calendar days followed by a written letter of action within forty-five (45) calendar days of receipt of provider's returned payment/check;

17) Process all adjustments and correct all related file/records within thirty (30) calendar days of receipt of the provider's returned payment/check. If resolution to the problem is so complex that additional time is required, the Contractor shall submit a written request to the Department for additional time. Whenever the Department grants an extension in writing, the affected provider shall in turn be notified in writing by the Contractor of the extension of time;

18) Research and process all other adjustments to adjudicated claims and provider payments as directed by the Department. Prior to initiating adjustment transactions, either on an individual claim basis or as part of a mass adjustment and/or recovery action, the Contractor shall first (1st) determine if the provider has already initiated the adjustment(s). If a provider has submitted a personal check to adjust an identified overpayment, the Contractor shall not

initiate an adjustment, and/or recovery action for the same overpayment.

All adjustments, including file/record corrections, shall be completed within thirty (30) calendar days of the date of the Department notice. The thirty (30) calendar-day limit may be extended if the Contractor requests an extension in writing and is approved by the Department. Upon completion of the adjustment, the Contractor shall notify the Department of the action. The notice(s) shall include dates of completion and rescheduled payments;

19) Generate actual fee-for-service payment(s) which shall be limited to the maximum allowable listed in the Schedule of Maximum Allowance (SMA) for maxillofacial surgical and temporomandibular joint (TMJ) service claims. All maxillofacial, surgical, and TMJ services requires prior authorization except for diagnostic services and services rendered on an emergency basis. The requirement of prior authorization may be waived where medical conditions or a time factor relating to treatment makes it inappropriate. Approval for payment of services provided in such circumstances rests with the Department based on submitted documentation justifying failure to obtain prior authorization;

20) Produce and distribute the yearly Federal 1099 information (MARS Report MR-O-020). The Contractor shall produce this information on the appropriate 1099 forms and distribute to the provider, the Internal Revenue Service, California Franchise Tax Board, the Department, and any other designated party; and

21) Generate payment(s) in accordance with the actual fee-for-service costs limited to the maximum allowable listed in the SMA for claims including OBRA/IRCA. OBRA/IRCA means the Omnibus Budget Reconciliation Act of 1986 and the Immigration Reform and Control Act of 1986.

5.4.13 CYCLE TIME REQUIREMENTS

The Contractor shall:

1) Comply with all State statutes and federal regulations; and

2) Ensure timely processing of documents. This section addresses the critical importance for timely processing and lists the performance requirements for payment as described in Exhibit A, Attachment II, Operations section. For payment of cycle time performance standards, the Contractor shall be

evaluated on a monthly basis. Conditions precedent to payment of the thirty-five percent (35%) cycle time component of the Contractor's monthly Operations invoice are itemized in Exhibit A, Attachment II, Operations, Claims Processing Cycle Time Requirements through Provider Cycle Time Requirements.

a) Claims, as referenced, refers to:

   i. Whole claim/NOA document;

   ii. Claims/NOAs without professional review;

   iii. Claims/NOAs with professional review; and

   iv. CIFs adjudicated as claims (for reevaluation and adjustments only).

      For CIFs adjudicated as claims, the Contractor shall calculate cycle time using the CRN Julian date as the calculation start date.

      All CIF processing requirements are addressed in Exhibit A, Attachment II, Operations, Provider Cycle Time Requirements.

b) TAR as referenced in Tar Processing Cycle Time Requirements refers to:

   i. Whole document;

   ii. TARs without professional review;

   iii. TARs with professional review; and

   iv. Reevaluations of denied TARs (TAR reconsiderations).

c) RTD processing requirements are also addressed in Claims Processing Cycle Time Requirements;

d) "Final adjudication" or "final adjudicate" is the date of the checkwrite or EOB for claim/NOAs. "Adjudication" and "final adjudication" for TARs are defined as the date the NOA is processed; and

e) All cycle times shall be computed on a monthly basis.

5.4.13.1 CLAIMS PROCESSING CYCLE TIME REQUIREMENTS

The Contractor shall:

1) Utilize the following calculation methodology when determining compliance with the time that claims/NOAs are in the following data control center (DCC) locations is excluded from the claims processing cycle time calculations:

   a) State review (DCC 3W, 4W, 5W, 6W, 7W);

   b) FAME recycle (DCC 3E);

   c) SOC recycle (MC177 facsimile mismatch) (DCC 3S);

   d) RTD time (DCC 6R);

   e) Clinical Screening (DCC 5G and 5P); and

   f) Claims/NOAs affected by a processing problem/error as defined in Exhibit A, Attachment II, Operations, Claims Processing Subsystem section.

2) Ensure Claims/NOAs requiring Contractor professional review shall be included in the overall processing time requirements of Claims Processing Cycle Time Requirements;

3) For claims where an RTD has been generated, exclude the time from receipt of the original claim to the date of receipt of the corrected RTD. The MRDCN shall be used to calculate cycle time;

4) For NOAs where an RTD has been generated, exclude the time from receipt of the NOA to the date of receipt of the corrected RTD. The MRDCN associated with the RTD (not the MRDCN associated with the NOA) shall be used to calculate cycle time;

5) Process and final adjudicate all claims/NOAs within an average of twenty (20) calendar days from receipt by the Contractor to checkwrite/EOB date;

6) Process and final adjudicate ninety percent (90%) of all claims/NOAs within twenty-five (25) calendar days and ninety-nine percent (99%) within fifty-five (55) calendar days from receipt by the Contractor to checkwrite/EOB date;

7) Generate and send an RTD for ninety percent (90%) of all claims/NOAs/TARs, which require additional information or correction to establish the validity of the claim/NOA/TAR, to the provider within twenty-five (25) calendar days and ninety-nine percent (99%) within thirty (30) calendar days with a

twenty (20) calendar-day average. The time claims/NOAs/TARs are in the following document control locations are excluded from the RTD processing calculation: State review, SOC recycle, FAME recycle, and claims affected by a processing problem/error as defined in Claim/TAR Adjudication Responsibilities;

8) Ensure that the number of claims/NOAs held for processing over thirty (30) calendar days shall not exceed nine percent (9%) of total claim/NOA inventory. Also ensure one hundred percent (100%) shall be processed within ninety (90) calendar days. Inventory is defined as non-adjudicated claims/NOAs in suspense and in "in process" DCCs, including daily receipts and daily cycle approved claims/NOAs. All claims/NOAs are considered in the inventory until the checkwrite/EOB date; and

9) Priority process claims as described in Claim/TAR Adjudication Responsibilities within five State workdays of receipt of the Department's request.

5.4.13.2 TAR PROCESSING CYCLE TIME REQUIREMENTS

This subsection addresses the Contractor's responsibilities for the timely processing of TARs and TAR reevaluations within the TAR processing system as required in Claim/TAR Adjudication Responsibilities. The requirements listed below exclude Clinical Screening Dentist screening time but includes professional review time.

The Contractor shall:

1) Utilize the following calculation methodology for determining compliance of TARs and TAR reevaluations:

   a) Exclude the following Data Control Centers (DCCs) from the TAR processing cycle time calculations:

      i. State review (DCC 3W, 4W, 5W, 6W, 7W);

      ii. FAME recycle (DCC 3E);

      iii. SOC recycle (MC177 mismatch) (DCC 3S);

      iv. RTD time (DCC 6R);

      v. Clinical Screening (DCC 5G and 5P); and

vi. TARs and TAR reevaluations affected by a processing problem/error as defined in Claim/TAR Adjudication Responsibilities.

2) TARs and TAR reevaluations provide professional review of within the overall processing time requirements;

3) Process and final adjudicate all TARs and TAR reevaluations within an average of fifteen (15) calendar days of receipt of the TAR/NOA;

4) Process and final adjudicate ninety percent (90%) of all TARs and TAR reevaluations within fifteen (15) calendar days and ninety-nine percent (99%) within thirty (30) calendar days;

5) Ensure that the number of TARs and TAR reevaluations held for final adjudication over twenty (20) calendar days shall not exceed nine percent (9%) of total inventory. No TAR or TAR reevaluation shall be over sixty (60) calandar days old. Inventory is defined as nonadjudicated TARs in suspense and in "in process" DCCs, including daily receipts and daily cycle approved TARs. TARs are considered in the inventory until the NOA is processed; and

6) Priority process TARs and TAR reevaluations, as described in Exhibit A, Attachment II, Operations, Claim/TAR Adjudication Responsibilities above, within five (5) workdays of receipt of the Department's request.

5.4.13.3 CLINICAL SCREENING DENTIST REVIEW CYCLE TIME REQUIREMENTS

This section addresses the Contractor's responsibilities for the timely processing of documents that require Clinical Screening Dentist review. The time it takes to reschedule an appointment when a beneficiary fails to show for a screening appointment shall be excluded from cycle time calculations. Clinical Screening Dentist review cycle time shall only pertain to the following document control locations:

1) Clinical Screening pre-schedule (DCC 5P); and

2) Out for screening (DCC 5G).

The Contractor shall:

1) Within thirty-five (35) calendar days process and enter back into the system ninety percent (90%) of all documents sent to Clinical Screening;

2) Within forty (40) calendar days process and enter back into the system ninety-nine percent (99%) of all documents sent to Clinical Screening;

3) Meet the following aging inventory standards:

   a) The number of documents held for Clinical Screening shall not exceed nine percent (9%) over thirty (30) calendar days; and

   b) Zero percent (0%) shall exceed sixty (60) calendar days.

4) Through the use of the MRDCN, calculate Clinical Screening time in 1), 2), and 3) above.

5.4.13.4 PROVIDER CYCLE TIME REQUIREMENTS

The Contractor shall:

1) Ensure Provider Cycle Time Requirements consist of the following categories:

   a) Provider suspense notification:

      i. All claims/NOAs suspended eighteen (18) calendar days or more; and

      ii. All TARs that have been suspended eighteen (18) calendar days or more.

   b) Respond to CIF Tracer:

      i. Claims/NOAs; and

      ii. TARs.

   c) Respond to CIF (Adjustments and Resubmittals) Claims/NOAs;

   d) Acknowledgment of CIFs received;

   e) Respond to phone calls;

   f) Acknowledge and respond to provider appeals;

   g) On the following checkwrite, report on the EOB one hundred percent (100%) of each provider's claims/NOAs, TARs and TAR reevaluations that have

been suspended eighteen (18) calendar days or more. These documents will appear on each subsequent EOB as documents “in process” until adjudicated;

h) Respond to ninety-five percent (95%) of all CIF tracers within fifteen (15) calendar days and one hundred percent (100%) within thirty (30) calendar days;

i) Respond to, process and final adjudicate ninety percent (90%) of CIF adjustments and resubmittals for claims/NOAs within twenty-five (25) calendar days and ninety-nine percent (99%) within fifty-five (55) calendar days with an eighteen (18) calendar-day average;

j) Acknowledge one hundred percent (100%) of CIFs received within five (5) State workdays;

k) Respond to one hundred percent (100%) of phone inquires within ten (10) State workdays;

l) Acknowledge one hundred percent (100%) of written grievances or complaints within 15 State workdays;

m) Issue a written notice to providers of findings/conclusions for one hundred percent (100%) of all provider appeals which do not require professional review, within thirty (30) calendar days of acknowledgment of receipt of provider appeals; and

n) Process and issue a written notice of findings/conclusions for one hundred percent (100%) of all provider appeals requiring professional review, within sixty (60) calendar days of the issuance of the acknowledgment letter.

5.4.14 PROCESSING REQUIREMENTS

This section defines additional performance requirements.

The Contractor shall:

1) Scan the form documents with optical character recognition (OCR) and intelligent character recognition (ICR) processing. Capture, correct, and validate all required fields of the form documents to include Claims, TARs, CIFs, returned RTDs, and NOAs to an electronic format. Assign a DCN, CRN, MRDCN, or other identifying number to each of the following documents whether received on hard copy or as electronic media documents; Claim, TAR, NOA, RTD, CIF, MC 177 facsimile, appeal, and supporting

attachments(s) indicating date of receipt. These documents then must be microfilmed within one (1) State workday of receipt by the Contractor;

2) Clearly identify on the Pended Claim History File and make available a record of one hundred percent (100%) of all claims/NOAs/TARs within seven (7) calendar days of receipt;

3) Within three (3) State workdays of receipt, reenter into the system one hundred percent (100%) of all suspended claims/NOAs/TARs that had been forwarded to the Department for resolution, and returned;

4) Mail RTDs to providers within three (3) State workdays of determination that a RTD is required;

5) Enter one hundred percent (100%) of claims/NOAs/TARs, and corrected RTDs returned from providers into the system within seven (7) State workdays from receipt by the Contractor; and

6) Return radiographs to the provider within eight (8) State workdays of adjudication of the Claim/NOA/TAR/CIF. The radiographs will be recycled in the event the provider does not want the radiographs returned.

5.4.15 TREATMENT AUTHORIZATION REQUEST (TAR) PURGE REQUIREMENT

The Contractor shall:

1) Purge approved and denied TARs from the database to a tape file to be retained for a period of no less than three (3) years;

2) Purge TARs according to the guidelines in the CD-MMIS documentation; and

3) Negate and purge an existing unused TAR when a new TAR is received from the same or a different provider for the same beneficiary and the same requested service(s) and the TAR is authorized. The Contractor shall, via telephone, notify the provider of the unused TAR of the action to be taken prior to voiding the approved TAR. A follow-up letter shall be sent to the provider of the unused TAR restating the action taken no later than three State workdays of the generation of the new NOA.

5.4.16 DOCUMENT RETRIEVAL RESPONSIBILITIES

The Contractor shall provide the capability to retrieve stored claims, related documents, forms and reports from requests submitted on-line or in written form, and track the distribution of each request. Documents that can be requested through the on-line Automated Document Retrieval (ADR) system include claims, NOAs, TARs, EOBs, CIFs, and RTDs. Requests for other documents are currently submitted in written form. The Contractor shall follow the retrieval methods and procedures for all documents described in the Records Retention Procedures Manual. (See Exhibit A, Attachment II, Operations, Records Retention Requirements).

5.5 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Determine the scope of dental program benefits, benefit limitations, and provide overall policy direction to the Contractor.

2) Issue Medi-Cal Beneficiary Identification Cards (BIC) and provide beneficiary eligibility and SOC certification information via FAME and AEVS;

3) Develop and maintain all policies and procedures related to TARs and Medi-Cal dental services requiring prior authorization;

4) Perform all tort liability, worker's compensation, probate or causality insurance recoveries and deposit into the Health Care Deposit Fund; and

5) Accumulate data and maintain file of beneficiaries with other health coverage.

6.0 MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM

6.1 OVERVIEW

The Medi-Cal Dental Program is an extremely complex multi-million dollar program that affects millions of beneficiaries and thousands of providers. The Management and Administrative Reporting Subsystem (MARS) is intended to provide timely and meaningful information necessary for effective program management and program activity. The MARS reports are the tools designed to present some of this necessary information.

MARS maintains the data files necessary to build a database of historic information to support the MARS reports produced by this subsystem. These reports include unduplicated counts of beneficiaries, providers, claims, NOAs, TARs, payments, and units of service.

The MARS reports are divided into the following general categories:

1) Administration - The administrative reports provide budget and financial data on processed claims/NOAs/TARs and on expenditures by provider specialty and claim type;

2) Operations - The operations reports provide claims payment data, TAR adjudication data and claims processing performance information;

3) Provider Services - The provider services reports present information reflecting provider participation, geographical location of providers, provider performance, amounts billed and payments issued;

4) Beneficiary Services - The beneficiary services reports contain information reflecting beneficiary participation and service usage; and

5) Managed Care and Capitated Programs – The managed care and capitated programs reports summarize encounter data, identifying beneficiary and provider utilization. In addition, provider participation and beneficiary/provider assignment reports are produced.

6.2 OBJECTIVES

The MARS has the following objectives:

1) To satisfy federal reporting requirements so the California Dental Medicaid Management Information System (CD-MMIS) qualifies for seventy-five percent (75%) Federal Financial Participation (FFP) and fifty percent (50%) FFP for administrative dollars;

2) To provide the information required for the review, development, monitoring, and regulation of dental policy;

3) To monitor claims processing activity and to provide summary reports of the status of claims in process and of adjudicated claims/NOAs;

4) To monitor TAR processing activity and provide summary reports which reflect current status of in-process and adjudicated TARs;

5) To provide summary reports that reflect payments for claims/NOAs including accounts receivable data;

6) To report monthly on beneficiaries with other dental insurance coverage. The report will display claim counts and dollar amounts cost avoided. The report should designate counts and dollar amounts due to health insurance Medicare Part A, and Medicare Part B. The report shall also include amount of all claims cost avoided or payments recovered when the contractor, or its parent entity, is the liable third (3rd) party;

7) To report provider payment participation characteristics to determine the adequacy and extent of participation and service delivery;

8) To report beneficiary participation characteristics in order to analyze usage and develop needed programs;

9) To report information about claims TAR adjudication in order to assist management in fiscal planning and control;

10) To provide the information necessary for the management and control of the claims processing system; and

11) To provide information showing the progress of Systems Development Notices and the Contractor's System Group.

6.3 ASSUMPTIONS AND CONSTRAINTS

1) The MARS function will be shared between the Department and Contractor. Information regarding both Department and Contractor produced reports are included in the various CD-

MMIS report user manuals found in the Office of Medi-Cal Procurement (OMCP) Data Library.

2) The scope of MARS data includes all CD-MMIS activity after beneficiary Medi-Cal eligibility has been established, including the adjudication and adjustment of claims. The data also contributes to the maintenance of provider relations, establishment and control of policy, change tracking system and contributing to fiscal planning and control of expenditures.

3) Effective fiscal control assumes accurate and timely claims/TARs processing and payment.

4) The reports produced by MARS in conjunction with those reports produced by other subsystems meet at least the minimum CD-MMIS requirements of all reporting levels in each functional area.

6.4 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Produce reports on the media specified in the CD-MMIS documentation for each report (e.g., paper, microfilm, microfiche, tape, diskette, on-line PC, direct electronic transmission);

2) Produce reports with the frequency indicated in the CD-MMIS documentation for each report (e.g., daily, weekly, monthly, quarterly, semi-annually, annually, calendar or contract year-to-date, and on-demand);

3) Produce reports that contain and reflect the Contractor's accumulated historical data as defined for each report in the CD-MMIS. TAR reports shall begin with TAR processing;

4) Generate all MARS reports produced by CD-MMIS. Reports shall meet requirements described in the Exhibit A, Attachment II, Operations, General Reporting Requirements Section, unless otherwise specified in this section;

5) Adhere to the report delivery requirements in the Exhibit A, Attachment II, Operations, General Reporting Requirements Section;

6) Update and maintain the Document (DCC) Criteria File (i.e., MR-F-007) within twenty-four (24) hours of receipt of Department approval of the Contractor proposed DCC changes; and

7) Accept and process the Medi-Care Buy-in data on a monthly basis.

6.5 DEPARTMENT RESPONSIBILITIES

The Department's responsibilities are addressed in the Exhibit A, Attachment II, Operations, General Reporting Requirements Section.

7.0 SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (S/URS)

7.1 OVERVIEW

The Surveillance and Utilization Review Subsystem (S/URS), operated and maintained by the Contractor, is one (1) part of the management information reporting capability of the CD-MMIS. The S/URS is a post-payment system designed to:

1) Provide a means to identify provider and beneficiary fraud and abuse; and

2) Provide a means to identify services provided which are below the community standard of care.

S/URS creates, over a period of time, statistical profiles detailing the services provided by providers, the utilization patterns of beneficiaries, and other related management information. In addition, it provides a method for Department staff:

1) To monitor the level of care being provided to beneficiaries;

2) To monitor trends in dental services that could lead to changes in program policy;

3) To document Medi-Cal dental annual income for the Internal Revenue Service or various court proceedings; and

4) To gather data reported in S/URS, taken from the Adjudicated Paid History Files in CD-MMIS.

Potential fraudulent provider practices are noted during utilization reviews. The most significant criteria applied is whether there is evidence of a pattern of inappropriate billings, inappropriate services, the degree of documented shortcomings, and financial gain accrued by the provider as a result of such practices.

S/URS allows the Department and the Contractor greater flexibility in the management reporting and investigating processes; this capability is primarily due to the user-controlled parameter-driven design.

S/URS provides flexibility in areas such as:

1) Availability of claims history data elements for computational and reporting purposes;

2) Capability of establishing statistical indicators (measurement items) as well as the methods used for their computation;

3) Ability to define class groups by specifying value limits for a desired set of available characteristics;

4) Ability to define normal values for group profile items;

5) Ability to control the comparison process by which individuals within a given class group are tested against that group's norms;

6) Ability to define the content of various reports;

7) Ability to assign priorities to discovered abnormalities; and

8) Ability to examine participants ranked according to significant statistical indicator values.

S/URS produces a series of statistical and detailed reports on Medi-Cal dental beneficiary and provider activities. S/URS obtains data on individual Medi-Cal beneficiaries and providers from all subsystems except MARS. This data is used to divide the beneficiaries and providers into peer or class groups according to various demographics and other characteristics as defined by the user. A behavioral profile is then developed for each class group and used as a baseline for evaluation.

S/URS also develops a behavioral profile for each beneficiary and provider in a class group. The purpose of the behavioral profile information is to assist Department staff in identifying activities that would be considered as normal and abnormal for each class group; the abnormal activities are referred to as exception situations. Exception situations are identified by comparing individual activity to class group norms. Exceptions are then "weighted", as determined by users, in order to produce ranked exception reports. The Contractor then notes exceptions to peer group or class norms that may indicate possible beneficiary and or provider abuse.

S/URS produces three (3) major sets of reports that reflect increasingly greater degrees of detail:

1) At the highest level are the Management Summary Reports which are the class group norms of care to which each beneficiary and provider is compared. The norms are developed by classifying each beneficiary and provider into the appropriate class group, computing a mean and standard deviation for each reporting category, then establishing a "range of tolerance" by adding a user-determined number of standard deviations to the mean.

Manual adjustment may be a fixed value or a change to the number of standard deviations. These norms are used to define exception limits. This method may result in statistically invalid norms, thus manual adjustment of the norms is a required feature of the S/URS.

2) The next level of reporting consists of Summary Profile Reports for each beneficiary and provider who has exceeded the norms (i.e., the exception limits) for that class group. These reports present an interrelated set of statistical indicators that have been selected to reveal areas of potential fraud and/or abuse.

3) The lowest level of reporting is the Claim Detail Report (CDR) produced for each beneficiary and provider, available upon request to the Department. These reports reflect detail from each adjudicated claim. For each beneficiary and provider, the claim details to be printed may be selected according to dates of service, procedure code, or various other criteria. A variety of print sequence options are also available.

The Contractor performs all S/URS case detection and development including all reviews and audits. All Contractor recommended actions are presented to the Department for review at Quality Review Committee (QRC) meetings and final decisions either during Case Review Committee (CRC) meetings, by letter, or by electronic mail.

7.2 OBJECTIVES

S/URS was developed to meet specific monitoring and reporting requirements of the Department. The goal of S/URS is to provide a manageable approach to the process of aggregating and presenting data on program beneficiary and provider activities in order to satisfy two (2) major concerns:

1) Surveillance - The process of monitoring the delivery and utilization of covered services by Medi-Cal dental beneficiaries and providers. Surveillance includes use of itemized data for overall program management and use of statistics to establish norms and averages so that unusual practices and potentially improper utilization can be detected; and

2) Utilization Review - The process of analyzing and evaluating delivery and utilization of services on a case basis to guard against fraudulent or abusive use of services by either providers or beneficiaries of the Medi-Cal Dental Program

and to identify those providers who provide services below the community standard of care.

7.3 ASSUMPTIONS AND CONSTRAINTS

1) The S/URS reporting capability is flexible.

2) The beneficiary and provider identification numbers are unique but can also be accurately cross-referenced.

3) The large volume of claims data requires consistently efficient and reliable operations for the timely and accurate production of reports.

4) S/URS operations require a close working relationship between the Contractor and the Department.

5) All S/URS reports will meet all reporting requirements in the Exhibit A, Attachment II, Operations, General Reporting Requirements.

7.4 CONTRACTOR GENERAL RESPONSIBILITIES

Prior to the implementation of any change that affects or alters S/URS operations, user interaction, reporting, data presentation, etc., the Contractor shall submit a written request to the Contracting Officer. This request shall include a description of the change and how it may affect existing procedures/operations, anticipated costs, and the projected implementation date. The request shall be submitted no less than thirty (30) calendar days prior to the projected implementation date, unless prior approval has been granted by the Contracting Officer.

7.4.1 SYSTEM REQUIREMENTS

The Contractor shall:

1) Acquire and maintain adequate resources (e.g., personnel, hardware, software) to accurately produce and deliver all required reports within the Department-designated timeframes as defined in the General Reporting Requirements section of the contract; perform provider and beneficiary utilization reviews; and consistently maintain the system's capabilities at a full operations status;

2) Maintain and continually update all history files and other data sources supporting the S/URS. The history files shall be updated with prior month activity no later than the fifth

(5th) day of each month to ensure that all data is current and the system provides the information necessary for the level of system-user interaction described in this contract; and

3) Ensure S/URS files are available for inquiry and/or update during the hours of 7:00 a.m. to 5:30 p.m., Monday through Friday, excluding state holidays. Any increase or decrease in availability requires prior approval from the Contracting Officer.

7.4.2 ORGANIZATION AND STAFFING FOR S/URS GROUP

S/URS staff shall include the following:

1) One (1) Director of S/URS

2) One (1) Administrative Assistant to the Director

3) Two (2) Senior Dental Consultants (California licensed dentists)

4) Six (6) Dental Consultants (California licensed dentists)

5) Two (2) S/URS Managers

6) Four (4) S/URS Liaisons

7) Four (4) Supervisors

8) Eight (8) On-site Audit Representatives

9) Four (4) Auditors

10) Six (6) Administrative Assistants

11) One (1) Technical Writer

12) Two (2) Research Analysts

13) Two (2) Project Analysts.

The following S/URS staff shall be subject to Department approval:

1) Director of S/URS

2) Senior Dental Consultants

3) Dental Consultants.

As part of the bid price for Operations, the Contractor shall provide the Director of S/URS and the Administrative Assistant to the Director. All remaining staff for the S/URS unit shall be cost reimbursed at the bid rates proposed by the Contractor. The actual number of cost reimbursed staff can range from forty (40) to sixty (60) as specified by the Contracting Officer.

Staff duties shall include, but are not limited to:

1) DIRECTOR OF S/URS shall:

   a) Direct the activities of the S/URS group; and

   b) Be the chairperson of the Case Review Committee (CRC); and the Quality Review Committee (QRC).

2) SENIOR AUDIT DENTAL CONSULTANT shall:

   a) Perform audits and exit conferences with providers;

   b) Supervise on-site audit team(s) activities;

   c) Analyze referral information and make recommendations to the Department for corrective action;

   d) Serve on the CRC and the QRC; and

   e) Be responsible for supervising and training Contractor on-site staff activities.

      Minimum qualifications shall include:

      i. Active dental license with good standing, issued by the Dental Board of California;

      ii. Ten (10) years clinical experience; and

      iii. Two (2) years experience in a S/URS related position.

3) AUDIT DENTAL CONSULTANT shall:

   a) Perform audits and exit conferences with providers;

   b) Process documents for providers on review/audit;

   c) Analyze referral information and make recommendations to the Department for corrective action; and

d) Serve on the CRC and the QRC.

Minimum Qualifications:

i. Active dental license with good standing, issued by the Dental Board of California; and

ii. Ten (10) years clinical experience.

4) PRIOR AUTHORIZATION/SPECIAL CLAIMS REVIEW (PA/SCR) SENIOR DENTAL CONSULTANT shall:

a) Process documents routed to the S/URS PA/SCR Unit;

b) Supervise the S/URS PA/SCR activities;

c) Make recommendations to the Department for corrective action;

d) Present and discuss S/URS PA/SCR findings of providers placed on sanctions to the Department;

e) Discuss with providers all issues related to PA/SCR sanctions;

f) Ensure all PA/SCR dental consultants maintain a minimum of ninety-nine percent (99%) accuracy level as defined in Exhibit A, Attachment II, Operations, Quality Management Operations section; and

g) Serve on the QRC and the CRC.

Minimum Qualifications:

i. Active dental license with good standing, issued by the Dental Board of California;

ii. Ten (10) years clinical experience; and

iii. Two (2) years experience in a S/URS related position.

5) PA/SCR DENTAL CONSULTANT shall:

a) Process documents routed to the S/URS PA/SCR Unit;

b) Make recommendations to the Department for corrective action; and

c) Maintain a minimum of ninety-nine percent (99%) accuracy level as defined in Exhibit A, Attachment II,

Operations, Quality Monitoring of Professional Review section.

Minimum Qualifications:

i. Active dental license with good standing, issued by the Dental Board of California; and

ii. Ten (10) years clinical experience.

6) S/URS ON-SITE AUDIT MANAGER shall:

a) Evaluate, monitor, and improve the quality and quantity of workflow of the on-site audit staff;

b) Determine staffing requirements; and

c) Provide analytical and computer system design support for S/URS activities and act as liaison between the Department and the Contractor's System Group for systems enhancements, problems, etc.

7) S/URS RESEARCH AND SUPPORT MANAGER shall:

a) Evaluate, monitor, and improve the quality and quantity of workflow of the Research and Support staff;

b) Determine staffing requirements;

c) Provide analytical and computer system design support for S/URS activities and act as liaison between the Department and the Contractor's System Group for systems enhancements, problems, etc.;

d) Ensure that the Contractor complies with the RFP requirements related to the timeframes associated with various S/URS reporting activities and that S/URS is updated and maintained properly;

e) Communicate verbally and in writing with all levels of Department management and staff, conduct meetings; and

f) Serve on the CRC and QRC as necessary.

8) S/URS LIAISON shall:

a) Review parameters of S/URS reports and request those reports as needed;

b) Review recommendations for administrative action against a provider;

c) Perform audit activities as needed;

d) Present recommendations to the Department for restricting a beneficiary's access to dental services;

e) Coordinate S/URS and CDR training for contract staff, and

f) Serve on the QRC and the CRC.

Minimum Qualifications:

i. Two (2) years of experience in dental billing and claims payment; and

ii. Fully trained in every aspect of S/URS operation prior to performing S/URS liaison activities.

9) ON-SITE AUDIT SUPERVISOR shall:

a) Supervise the On-site staff who are responsible for beneficiary and provider utilization review; and

b) Serve on the QRC and the CRC as needed.

Minimum Qualifications:

i. Two (2) years experience as On-Site Audit Representative

10) PA/SCR SUPERVISOR shall:

a) Supervise the PA/SCR auditor staff; and

b) Serve on the QRC and the CRC as needed.

11) BENEFICIARY FRAUD SUPERVISOR shall:

a) Supervise the beneficiary fraud staff; and

b) Serve on the QRC and the CRC as needed.

Minimum Qualifications:

i. Two (2) years experience in beneficiary fraud casework.

12) RESEARCH AND SUPPORT SUPERVISOR shall:

a) Supervise the research and support staff; and

b) Serve on the QRC and the CRC as needed.

Minimum Qualifications:

i. Two (2) years experience in research and support activities; and

ii. Two (2) years experience performing research data collection.

13) ON-SITE AUDIT REPRESENTATIVE shall:

a) Perform on-site audits under the supervision of the On Site Audit Supervisor; prepare cases for on-site audits;

b) Prepare case summary of findings resulting from on-site audits and participate in exit conferences with providers;

c) Perform audit activities for S/URS Liaisons as needed;

d) Submit recommendations to the Department for corrective action; and

e) Serve on the CRC and the QRC as needed.

Minimum Qualifications:

i. Minimum two (2) years experience in dental billing and claims payment and/or dental office experience.

14) ADMINISTRATIVE ASSISTANT (Beneficiary Fraud) shall:

a) Request and analyze data dealing with beneficiary utilization, make recommendations to the Department and take appropriate actions regarding suspected beneficiary fraud;

b) Analyze, compile and communicate with the Department and providers regarding beneficiary fraud;

c) Prepare summaries and review paid claims history to rule out clerical or automated systems error;

d) Request patient records related to conflicting history; forward the records for review to a S/URS dental consultant; and

e) Maintain files on cases of suspected program misuse.

15) ADMINISTRATIVE ASSISTANT (ON-SITE AUDIT) shall:

a) Prepare, track and process the recovery of overpayments paid to providers following a determination of fraud, abuse, or poor quality of care from an on-site audit, post treatment examination, or provider fraud investigation as directed;

b) Prepare, send and follow-up on required corrective action letters to providers when it has been determined that poor quality services have been rendered as a result of post-treatment examination by second opinion clinical screening, or a S/URS on-site audit;

c) Perform the necessary steps of recoupment and maintain the CD-MMIS database; and

d) Serve on the CRC as needed.

16) PA/SCR AUDITOR shall:

a) Process documents for the PA/SCR unit that do not require professional review by PA/SCR dental consultants; and

b) Make recommendations for corrective action.

17) TECHNICAL WRITER shall:

a) Work with the Department and the Contractor's legal counsel to develop letters to providers, attorneys, and other entities regarding S/URS actions;

b) Assist in the preparation and updating of manuals used by the Department and S/URS staff; and

c) Act as a resource to S/URS staff for Title 22, California Code of Regulations, Welfare and Institutions Code, and any other authority, regulation, or statute governing the Medi-Cal Dental Program.

Minimum Qualifications:

i. Two (2) years technical writing; and

ii. Writing experience preparing research manuals and/ or technical manuals.

18) PROJECT ANALYST shall:

a) Gather, compile, analyze and interpret data on beneficiaries and providers placed on S/URS sanctions;

b) Prepare research and statistical reports for providers on S/URS sanctions; and

c) Provide to the Department monthly listings of active and inactive providers subject to PA/SCR.

Minimum Qualifications:

i. Knowledge of research methods and techniques; and

ii. Knowledge of CD-MMIS is desirable.

19) RESEARCH ANALYST shall:

a) Create, compile, analyze and interpret data on providers and beneficiaries suspected of fraud and/or abuse.

Minimum Qualifications:

i. Knowledge of information technology systems and software;

ii. Knowledge of research methods and technologies; and

iii. Knowledge of CD-MMIS is desirable.

The duties mentioned above are **not** meant to be a complete or comprehensive list of duties to be performed by each class listed. When additional duties are required to carry out the mission of the S/URS Group, the Contractor shall assure that these duties are assigned to the appropriate S/URS staff and are completed.

The Contractor shall make available to the S/URS operation necessary legal counsel to support and advise S/URS staff in development and implementation of policy for Department consideration. Legal counsel will advise S/URS staff in the development of letters to beneficiaries and providers, attorneys and other entities, preparation of audit criteria and audit reports, meeting with and responding to requests by the Department for matters involving courts, other state agencies and the public, etc. Legal advice is mandatory to the S/URS operation prior to presentation of any S/URS issues to the Department.

The Contractor shall make all S/URS staff accessible to Department designated personnel during the State working hours of 8:00 am to 5:00 pm PST, Monday through Friday, excluding state holidays. (i.e., for personal interaction or other verbal communication).

7.4.2.1 S/URS TRAINING

The Contractor shall:

1) Provide periodic S/URS training and CDR training within thirty (30) calendar days of receipt of the Department's written directive. The Department's request will specify the number of persons to be trained. This training is in addition to all other training required by this contract;

   The purpose of the S/URS and CDR training shall be to fully orient, acquaint and increase the knowledge and level of competence of Department staff working with S/URS;

2) Ensure that the S/URS training, at a minimum, include:

   a) S/URS operations including provider/beneficiary utilization review;

   b) User interactions;

   c) A review of the S/URS user manual;

   d) Use of the PC including hands-on training;

   e) Procedures for ordering CDRs (overview);

   f) S/URS reports;

   g) Any changes to S/URS operations that were initiated after the effective date of the contract;

   h) The Contractor's procedures for meeting all S/URS contract requirements;

   i) A tour of the Contractor's Sacramento facility, when specifically requested;

   j) Procedures for ordering Aged History Reports (AHR); and

k) S/URS training shall be limited to one (1) session each calendar quarter. All sessions shall be conducted in Sacramento.

3) Ensure CDR training may be requested by the Department as many times as deemed necessary each State fiscal year; The Contracting Officer may designate some of these sessions be conducted outside the Sacramento area and will specify the location for each of these training sessions. CDR training shall be given to no more than twenty-five (25) Department designated personnel per year;

4) Ensure that the CDR training shall, at a minimum include:

a) Procedures for ordering CDRs;

b) Procedures for ordering Aged History Reports;

c) Use of the PC including hands-on training;

d) CDR format and content;

e) Data sources; and

f) A tour of the Contractor's facility, when specifically requested.

5) Determine the number of personnel to participate and number of sessions required per training request. This decision shall be based on information provided by the Contractor, who shall deliver to the Contracting Officer a written plan for the training and orientation. The plan shall include the training format, subject areas, teaching and visual aids, the optimum and maximum number of individuals per group/session, and total number of hours required to complete the training, including the facility tour;

6) Ensure the training plan shall also include the professional qualifications of each trainer (i.e., the trainer's current job classification and responsibilities, his/her knowledge and experience in the assigned subject(s), and his/her ability to impart that knowledge to others) also;

7) Submit the written training plan to the Contracting Officer for review and approval no more than five (5) weeks after the contract effective date.

If the Contracting Officer directs that specific changes/additions be made to the plan, the Contractor shall have thirty (30) calendar days from receipt of the Contracting Officer's directions to make the modifications;

8) Upon request of the Department, provide a written report detailing the progress and status of the actual CDR Training compared to the CDR Training Plan submitted five (5) weeks after the effective date of the contract; and

9) Periodically notify the Contracting Officer of all proposed modifications to the training plan that reflect the most recent and up-to-date changes in S/URS and CDRs. This notice shall be in writing and submitted for approval every ninety (90) calendar days, even if no changes to the S/URS and CDRs have occurred.

7.4.3 REPORT PRODUCTION

The Contractor shall:

1) Generate all S/URS reports produced by the CD-MMIS. Reports shall meet the requirements described in this section and in the General Reporting Requirements. If inconsistencies are identified, the S/URS section shall take precedence;

2) Unless otherwise specified, produce reports on paper and one (1) copy per requester. A “requester”, for S/URS report delivery purposes, shall be the specific State delivery addressee; and

3) When the dates given in this section fall on non-State workdays, the next State workday shall apply.

7.4.3.1 CLAIM DETAIL REPORTS (CDRs)

CDRs are provider and beneficiary claims payment history records.

The Contractor shall:

1) Produce CDRs each State workday of the year. Beneficiary and provider CDRs shall be produced upon request. The Contractor shall deliver local CDRs in print, diskette, or tape format within a twenty-four (24) hour period. “Local” deliveries shall be to any location within twenty-five (25) miles of the State Capitol Building;

2) Maintain and update CDR Requester Numbers (CDRRN) file weekly and make CDR distributions accordingly. CDR requests and CDRRN are input at the same time. CDRRNs

are assigned by the Department and identify the requestor and the respective report delivery address; and

3) Produce CDRs for payment data for the most recent seventy-two (72) months of dental service history and once-in-a-lifetime procedures.

7.4.3.2 STATISTICAL SAMPLING MODULE AND REPORTS

The S/URS Statistical Sampling Module and Reports enables authorized S/URS users to produce reports based on random samples of paid claims drawn from the thirty-six (36) Month Provider Paid Claims History File.

Sampling reports shall be produced on a monthly basis. Input requests provided by the first (1st) of the month shall be delivered by the fifteenth day of the same month. Input requests prior to the fifteenth of the month shall be delivered by the end of the same month.

The number of samples requested by the Department through this module shall not exceed three hundred (300) during any contract year.

7.4.3.3 PROVIDER AND BENEFICIARY PROFILING

Each calendar quarter, the profiling process shall be run for beneficiaries and for providers.

The Contractor shall:

1) Be responsible for notifying the Contracting Officer each calendar quarter to set the parameters for the quarterly cycle of provider and beneficiary profiling;

2) Be responsible for the post payment utilization review of exceptional providers and beneficiaries identified through the exception processing system; and

3) Submit all reports related to the Provider and Beneficiary Profiling Modules on paper, microfiche, Compact Disk, or other media when requested by the Contracting Officer.

7.4.4 PROVIDER UTILIZATION

The Contractor shall:

1) Be the user of the quarterly cycle of provider profiling and be responsible for the utilization review of those providers identified as being potential overutilizers of the program through the exception processing system;

2) Set the parameters for identifying exceptional providers and submit them to the Department for review and approval;

3) Update and maintain on a monthly basis, the Fraud and Abuse/Quality of Care Manual and the Provider Utilization portion in the S/URS Users Manual throughout the term of the contract. These manuals shall describe all methods and procedures governing provider utilization review; and

4) Maintain documentation of the entire utilization review process to form an audit trail of utilization review activity. This documentation shall be made available to the Department within two State workdays of a written request. The documentation shall include but not be limited to the following:

   a) All copies of reports;

   b) All written documentation of findings;

   c) All documentation of findings from reviews;

   d) All report pages appropriate to each utilization review process;

   e) All notes (e.g. electronic mail) (notes shall be maintained throughout this process);

   f) Any other relevant information relating to the review process; and

   g) Meet the annual federal S/URS System Performance Review (SPR) requirements.

7.4.5 S/URS CASE REVIEW COMMITTEE (CRC)

The Contractor shall:

1) Establish a CRC comprised of the Contractor S/URS and management staff and representatives of the Department, to be selected by the Contracting Officer, to review and evaluate findings from audits and reviews and make recommendations to impose sanctions when appropriate;

2) Prepare agenda and record minutes of the CRC. The draft minutes shall be reviewed and approved by the Department prior to recording the final version.;

3) Include in the CRC, but not be limited to, the following Department staff:

   a) Manager of the Provider Fraud and Abuse Detection Unit, Medi-Cal Dental Services Branch;

   b) Dental Consultant of the Provider Fraud and Abuse Detection Unit, Medi-Cal Dental Services Branch; and

   c) Analysts of the Provider Fraud and Abuse Detection Unit, Medi-Cal Dental Services Branch.

4) The CRC will consist of the following Contractor staff:

   a) Director of S/URS (Chair of the Committee)

   b) S/URS Senior Dental Consultants

   c) S/URS Audit Dental Consultants

   d) S/URS Managers

   e) S/URS Liaisons

   f) S/URS Supervisors (as needed)

   g) S/URS On-Site Representatives

   h) S/URS Administrative Assistant for the Director

   i) S/URS Research Analysts

   j) S/URS Project Analysts.

5) Ensure that attendance at CRC meetings by S/URS staff be kept to a minimum by requiring that only staff members who have agenda items to discuss will be present;

6) Apply the following guidelines for the identification of exceptional providers:

   a) Each quarter review at least one percent (1%) of the total body of the most recent calendar-quarter of all active dental providers. At least eighty percent (80%) of the dental providers to be reviewed must be selected from those identified through the ongoing exception process. Up to twenty percent (20%) of the cases to

be reviewed may be identified through other sources, such as referrals, complaints or inquiries;

b) From those providers reviewed in (a) above, examine all, but select a minimum of fifty percent (50%) of those providers for a comprehensive desk review. The desk review of a provider's Summary Profile, shall also include an analysis of associated CDRs and other reports or documentation. The primary purpose of the desk review is to develop cases for audits. The audits may involve on-site audit team activities or internal review of documents readily available through various reports or other sources;

c) Determine which review cases developed in (b) above are to be the object of an audit. At a minimum, fifteen (15) providers per quarter shall have an audit. Prepare an integrity review case package for the audit staff that shall include at a minimum:

i. A listing of the services to be audited;

ii. Source of the review (S/URS or other);

iii. For S/URS cases the provider's Summary Profile cases;

iv. If other than a S/URS case, the referral, compliant or inquiry document that prompted the development of the case;

v. Provider and recipient Claim Detail Reports as necessary;

vi. Provider Master File data which includes fiscal and claim information;

vii. A report from the integrity review staff to include: associated documentation; a summary of findings and analysis; and recommendations; and

viii. Audit work sheets.

7) Conduct post-service/post-payment audits of providers suspected of misutilizing or abusing the program. The audit is to verify misutilization or abuse and to initiate administrative sanctions when appropriate. Below are the phases and guidelines to be followed for each audit:

a) Phase 1 **Pre- Audit Review**

A pre-Audit review is to be completed by the Contractor's S/URS staff at the Sacramento facility. Staff shall determine the need for an audit and then, upon Department approval, inform the provider in question of the date(s) and time(s) of the planned audit.

b) Phase 2 **Field Audit**

Should the audit require a field visit (on-site), then the audit shall be conducted by the Contractor's Sacramento staff. Staff shall include a S/URS Audit Dental Consultant and an On-Site Audit Representative. Staff shall examine the provider's records to determine if misutilization or abuse is occurring. The on-site audit shall at a minimum include:

i. Provider entrance conference;

ii. Provider information interview, to provide information on provider's organization, staffing, billing and other operational arrangements;

iii. Tour of the provider's facility;

iv. Review of the provider's patient records;

v. Copy the predetermined number of patient charts for review at Contractor's facility. The number of patient charts subject for review may range from thirty-five (35) to four hundred (400) or be a Statistically Valid Sample (SVS). The Department shall determine which methodology to utilize;

vi. Analysis of findings;

vii. Determination if further expansion of the audit is needed;

viii. Inform the provider that an Exit Conference will be scheduled at a later date and that a Preliminary Audit Report (PAR) will be forth coming; and

ix. An audit team/Contractor management meeting shall be held with the Department to discuss the preliminary findings of the audit. The Contractor shall present its preliminary findings and recommendations to the Department during the

QRC meeting. Formal approval from the Department to issue the PAR to the provider will occur at a subsequent CRC meeting. The Department may request the Contractor to revisit the provider's facility to obtain additional information.

c) Phase 3 **Post Audit**

Following the field audit, or retrieval of information, the S/URS staff shall review and prepare a preliminary report of findings. The post audit shall include:

i. An exit conference to be held following the Department's prior approval at CRC meetings either via telephone conference call with the provider or at the providers discretion shall be conducted at the Contractor's Sacramento facility. The purpose of the exit conference is to present the provider with the preliminary audit report and allow the provider the opportunity to present input prior to the issuance of the final audit report;

ii. While at the exit conference, the audit team shall give the provider an acknowledgment letter to sign either by facsimile or in-person that states the provider has been advised of the contents of the PAR and gives the provider fifteen (15) calendar days to provide additional information as defined by Title 22, California Code of Regulations, Welfare and Institutions Code and any other code regulation or statute governing the Medi-Cal Dental Program. Copies of the above cites shall be given to the provider at the time the PAR is issued. The acknowledgment letter also states the provider has the right to appeal any audit findings with which the provider is not in agreement;

iii. The findings of the exit conference shall be incorporated into the Final Audit Report (FAR) to be sent to the provider. This FAR will be presented to the Department for approval prior to the QRC meeting. Upon approval at QRC meeting, the FAR will be presented for final approval for issuance to the provider at a subsequent CRC meeting;

iv. The Contractor shall prepare a final case package, which contains all required documents for the administrative action. At this time, letters

to the provider and any other agencies (e.g. Dental Board of California), at the Department's request, are prepared, informing each of the final decision and actions to be taken;

v. Take the approved administrative actions;

vi. Make recoveries of overpayments identified during the audit process. The Contractor shall report to the Department by the last business day of each month the current dollar amount of recoveries made from an individual provider. The total amount recovered from all providers will be used by the Department as an adjustment against the total amount paid to dental providers for rate setting purposes. Should the provider not fully satisfy the terms of demand for repayment, interest, as determined by the Department, shall be charged beginning the sixty-first (61^{st}) calendar day after the date of the demand. The Contractor shall submit to the Department by the last business day of each month a report summarizing the status of the dollar amount of recoveries from each provider subject to repayment;

vii. Forward cases of potential fraudulent provider practices noted during the utilization review to the Department for possible action;

viii. Generate all provider utilization review reports produced by the CD-MMIS. Ad Hoc reports via Services, Tracking And Reporting System (STARS) shall be utilized as necessary in the process. The reports shall meet the requirements described in Exhibit A, Attachment II, Operations, General Reporting Requirements Section of the contract;

ix. Assist the Department in requests for recommendations on appeals forwarded from the Department's Office of Administrative Hearings and Appeals; and

x. The final audit report shall be issued to the provider no later than one hundred eighty (180) calendar days from the date of the audit. If the audit is comprised of a chart retrieval from the provider's office, the date of the audit is considered to be the date the charts are completely retrieved from the provider's office.

7.4.6 BENEFICIARY UTILIZATION REVIEWS

The Contractor shall:

1) Be the user of the quarterly cycle of beneficiary profiling and be responsible for the utilization review of those beneficiaries identified as being potential overutilizers of the program through the exception processing system;

2) Set the parameters for identifying exceptional beneficiaries to detect billing conflicts of procedures on the same patients utilizing History Cross Check of TARS;

3) Maintain and update on a monthly basis, the Fraud and Abuse/Quality of Care Manual and Beneficiary Utilization Section in the S/URS User Manual throughout the term of the contract. These manuals describe all methods and procedures governing utilization review;

4) Maintain documentation of the entire utilization review process to form an audit trail of utilization review activity for each case. This documentation shall be made available to the Department within two (2) State workdays of a written request. The documentation shall include but not be limited to the following:

   a) All copies of reports;

   b) All written documentation of findings;

   c) All documentation of findings from other sources;

   d) All notes (e.g. electronic mail) (notes shall be maintained throughout this process);

   e) All report pages appropriate to each utilization review process; and

   f) Any other relevant information relating to the review.

5) Provide for S/URS post-treatment screening services pursuant to the Fraud and Abuse/Quality of Care Manual and S/URS User Manual;

6) Meet the annual federal S/URS SPR requirements;

7) Apply the following guidelines for the identification of exceptional beneficiaries:

a) Each quarter review at least one-50th (1/50th) of one (1) % of the total body of active beneficiaries. At least eighty percent (80%) of the beneficiaries reviewed must be selected from those identified through the ongoing quarterly exception process. Up to twenty percent (20%) of the beneficiaries to be reviewed may be identified through other sources such as referrals, complaints or inquiries;

b) Each quarter, submit for Department review and approval all documentation regarding each beneficiary review case with the Contractor's recommended action to be taken (e.g. restriction);

c) Take action to impose the restriction previously approved by the Department;

d) Edit claims for beneficiaries that have been placed on restriction;

e) Provide assistance to the Department when it conducts a Fair Hearing for a beneficiary that protests the imposition of a restriction for dental services. The Contractor shall provide all documentation related to the beneficiaries' case within three (3) State workdays of the request, prepare a written position statement of reason(s) for restriction and make S/URS staff available to represent the Department in the Fair Hearing, if requested by the Department;

f) Forward cases of potential beneficiary fraud and abuse activity to the Department following completion of beneficiary utilization reviews. (See Fraud and Abuse/Quality of Care Manual); and

g) Generate all beneficiary utilization reports produced by the CD-MMIS. Ad hoc reports via STARS shall be utilized as necessary in the process. The reports shall meet the requirements described in Exhibit A, Attachment II, Operations, General Reporting Requirements Section of the contract.

7.4.7 S/URS QUALITY REVIEW COMMITTEE (QRC)

1) Establish a QRC comprised of the Contractor's S/URS and management staff and representatives of the Department to be selected by the Contracting Officer, to review and evaluate: findings of cases referred to S/URS because of possible substandard care, providers being recommended for sanctions or audit, review of providers already subject to

sanction, review findings of PARs and FARs. The QRC's findings will be presented at the CRC meeting for final decision.

2) Prepare an agenda and record minutes of the QRC. The draft minutes shall be reviewed by the Department prior to recording the final version,

3) The QRC will consist of the following Department staff:

   a) Dental Consultant, Provider Fraud and Abuse Unit, Medi-Cal Dental Services Branch; and

   b) Analysts, Provider Fraud and Abuse Unit, Medi-Cal Dental Services Branch.

4) The QRC will consist of the following Contractor staff:

   a) Director of S/URS Department (Chair of the Committee)

   b) S/URS Senior Dental Consultants

   c) S/URS On-Site Audit Dental Consultants

   d) S/URS Managers

   e) S/URS Liaisons (as needed)

   g) S/URS Supervisors (as needed)

   g) S/URS On-Site Representatives (as needed)

   h) S/URS Administrative Assistant for the Director

   i) S/URS Research Analysts (as needed)

   j) S/URS Project Analysts (as needed).

5) The Contractor shall ensure that attendance at QRC meetings by S/URS staff be kept to a minimum by requiring that only staff members who have agenda items to discuss will be present; and

6) Utilize the QRC to review and evaluate those provider and beneficiary cases that have been identified as possible fraud and/or abuse cases.

7.4.8 S/URS USER MANUAL

The Contractor shall maintain and update the S/URS User Manual throughout the term of the contract, to reflect Department approved changes. The manual shall clearly describe in lay terms the Contractor's S/URS operation, user intervention and procedures, system capabilities and limitations, description and use of CD-MMIS screens, building of parameters and their range uses.

7.4.9 QUALITY OF CARE

The Contractor shall:

1) Develop an operational quality of care review plan and system employing the services of California licensed dentists and paraprofessionals to ensure quality dental care is provided to beneficiaries by continually assessing and addressing problems brought to its attention by various sources, e.g., Contractor's dental professional/paraprofessional staff, including clinical screening dentist staff; dental record/claim/TAR audits; beneficiary complaints; complaints or concerns resulting from a beneficiary referral or advocacy groups; statistical reports, etc.;

2) Implement a quality of care review system that will be based upon the community standard of care in the dental profession and will contain the following attributes:

   a) Identification of less than satisfactory performance of elements of care by considering information from all reasonably available sources, some of which are listed above;

   b) Establishment of valid and achievable dental standards for those identified elements of care that are amenable to standard setting and compliance measurement;

   c) Assurance that those standards that are established will be related to conditions that can be affected by dental intervention that are within the scope of benefits in the program, can apply to a significant number of beneficiaries and apply to all providers, not just one (1) class of providers;

   d) Documentation of staff meetings dealing with this requirement and any assistance sought from and given by sources outside Contractor's staff;

   e) Objective measurement of actual performance as reflected in data gathered from dental records, beneficiary complaints and other sources so as to

include a representative sample of all such performance, to determine apparent noncompliance with standards;

f) Analysis by Contractor professional staff of the results of objective measurement as to their validity;

g) Submittal of the proposed plan which shall be delivered to the Department for approval thirty (30) calendar days before claims processing is initiated, then the manual shall be updated every twelve (12) months thereafter. All recommendations to the Department for review and approval, if acceptable, (a) at the same time such documentation must be made available to staff from the Department of Managed Health Care; or, (b) if currently Knox-Keene licensed, seven months from contract effective date. The plan should include specific recommendations regarding proposed corrective actions that can be taken to improve the quality of care for Medi-Cal dental beneficiaries and possible methods to follow-up to ensure the corrective actions have been effective; and

h) Following Department approval, the Contractor shall implement the plan in accordance with the Contracting Officer's directives.

7.5 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Produce the Fraud and Abuse/Quality of Care manual and maintain throughout the term of the contract. The manual shall be delivered to the Department for approval thirty (30) calendar days before claims processing is imitated, then the manual shall be updated every twelve (12) months thereafter. The manual shall describe all methods governing fraud and abuse and the quality of care review system;

2) Detect potential occurrences of fraud and abuse associated with provider or beneficiary claim activity and correspondence;

3) Produce and distribute to the Department a monthly report due by the last business day of each month. The report shall include:

   a) Newly detected fraud and abuse activity by providers and beneficiaries; and

b) The status of previously identified fraud and abuse cases that were returned to the Contractor for action and recovery.

4) Be responsible for recoupment action identified as necessary during the audit process for fraud and abuse cases;

5) Provide to the Department within three State workdays of any request all reports, information and documentation to facilitate any audit or investigation of potential provider and/or recipient fraud and abuse;

6) Upon Department request, provide expert witness services on contractual definitions or benefit coverage and necessity in fraud, abuse, civil, and administrative legal proceedings. The Contractor shall hire a court experienced expert witness to handle specialty cases such as orthodontics on an on-call basis;

7) Develop procedures to ensure that audits can be conducted employing a Statistically Valid Sample (SVS). The Contractor shall be responsible for ensuring that the method can be validated using guidelines established by members of the American Statistical Association. The Contractor shall present to the Contracting Officer the proposed methodology prior to its implementation;

8) Ensure any and all policies or procedures as defined in this S/URS section be in compliance. If determined to be out of compliance, then liquidated damages, as set forth in Exhibit E, Additional Provisions, shall apply; and

9) Ensure the duties and/or requirements as outlined in this section are adhered to. Should the Contractor fail in this regard and this results in an award against the department or results in the Department losing the ability to recover overpayments, then those amounts shall be paid according to the judgments directed by the Court or other administrative body. These amounts shall not come from the Pure Premium Fund and shall not be subject to the calculation of the gain/loss of that fund.

7.6 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Review and approve/disapprove all S/URS manuals, report parameters, and proposed administrative actions against providers/beneficiaries;

2) Approve/disapprove providers recommended for audit as well as any FAR and/or PAR performed;

3) Serve on the CRC;

4) Serve on the QRC;

5) Request S/URS and CDR training to be conducted by the Contractor; and

6) Refer matters of suspected fraud and/or abuse by recipients and providers to the Department's Deputy Director, Audits and Investigations.

8.0 BENEFICIARY SERVICES

8.1 OVERVIEW

Beneficiary Services shall provide for centralized control of all beneficiary communications. This encompasses functional responsibilities for beneficiary telephone service center operations; receipt and resolution of beneficiary inquiries, complaints, and grievances; assisting beneficiaries in securing Medi-Cal dental provider referrals in their geographical area; securing clinical screenings for the purpose of obtaining a "second opinion"; providing written notifications to beneficiaries on treatment authorization request decisions; and the processing of beneficiary appeals of denied services, hereafter referred to as dental fair hearing requests.

8.2 OBJECTIVES

Beneficiary Services shall:

1) Ensure Toll-free telephone access is available to beneficiary and/or authorized representative inquiries, complaints, etc., related to the Medi-Cal Dental Program;

2) Ensure beneficiary complaints, grievances, and/or requests for clarification of denied (or modified) services are thoroughly researched, analyzed, and responded to in compliance with Knox-Keene licensing requirements or as listed below, whichever is less:

   a) Fair hearings are not to exceed thirty (30) calendar days;

   b) Clarifications shall be responded to on the same day;

   c) Complaints shall be acted upon within three (3) State workdays and resolved within thirty (30) calendar days; and

   d) Referrals shall be responded to on the same day, if possible, but no more than five (5) State workdays.

3) Ensure beneficiaries are provided with assistance in locating a Medi-Cal dental provider within their geographical location;

4) Ensure beneficiaries are mailed a notification when services that require prior authorization are denied or modified, within five (5) State workdays after the Fiscal Intermediary Access

of Medi-Cal Eligibility (FAME) tape has been received to obtain beneficiary address information;

5) Ensure clinical screening appointments are scheduled within eleven (11) State workdays of determination of need;

6) Ensure new dental fair hearing requests are electronically entered onto the Department's fair hearing data base on a daily basis and case files are created and/or updated as dental history is compiled and analyzed;

7) Ensure fair hearing position statements (including beneficiary dental history) and/or proposed withdrawal letters are developed in accordance with Beneficiary Services – Dental Fair Hearings requirements; and

8) Ensure all dental service(s) authorized in a beneficiary's "final" fair hearing decision are reflected in the fair hearing database to show beneficiary history, payment and dates of case closure.

8.3 ASSUMPTIONS AND CONSTRAINTS

Beneficiary Services is subject to the following assumptions and constraints:

1) Beneficiary Telephone Service Center (TSC) is to be staffed between the hours of 8:00 a.m. and 5:00 p.m. PST, Monday through Friday, excluding State holidays; unless stated otherwise in this section;

2) The weekly average number of incoming calls blocked (calls receiving a busy signal) shall be no greater than seven percent (7%), hereafter referenced as the "P" factor;

3) Voice mail messages from beneficiaries shall be returned within one (1) State workday;

4) Beneficiary TSC operators shall have access to all on-line systems containing active Medi-Cal dental providers, beneficiary dental histories, and/or hard copy references to fully support the telephone function;

5) Beneficiary complaints/grievances, written or verbal, shall be researched and responded to within the time frames previously stipulated and the outcome data incorporated into the beneficiary's dental history;

6) Within thirty (30) calendar days of the receipt of a fair hearing request, a fair hearing position statement and/or a

proposed letter of withdrawal to the beneficiary, hereafter referenced as a "conditional withdrawal letter", are to be prepared for the Department's review and approval. Fair hearing position statements and conditional withdrawal letters shall be prepared for the Contracting Officer's signature; and

7) A roster of screening dentists shall be maintained to perform second opinion clinical screenings requested on dental treatment plans and/or on previously provided dental services that may relate to dental fair hearing cases.

8.4 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Ensure beneficiary TSC access and clinical screening functions are operational at the start of TAR processing and maintained thereafter;

2) Ensure beneficiary TSC operators have access to all reference materials required to perform beneficiary service functions by the start of TAR processing and maintained thereafter;

3) Ensure beneficiary complaint, grievance, and fair hearing processes are operational at the start of TAR processing and maintained thereafter;

4) Ensure beneficiary notification of denied and/or modified services that require prior authorization are operational at the start of TAR processing and maintained thereafter;

5) Maintain the ability and the capability to accept, resolve and respond to beneficiary requests for assistance within the time frames previously stipulated;

6) The Contractor shall develop a dental outreach and education program for Medi-Cal beneficiaries in accordance with Welfare & Institutions Code 14132.91 regarding recommended frequencies for regular and preventive dental care, how to obtain Medi-Cal dental care, how to avoid inappropriate care or fraudulent providers, and how to obtain assistance in getting care or resolving problems with dental care. This plan shall be delivered to the Department for review and approval on an annual basis by the end of each calendar year; and

7) Ensure that any individual representing themselves as an "authorized representative" of a Medi-Cal beneficiary are in

compliance with the federal HIPAA requirements prior to disclosing beneficiary specific information.

8.4.1 BENEFICIARY TELEPHONE SERVICE CENTER OPERATIONS

The Contractor shall:

1) Ensure beneficiary TSC staff is knowledgeable in the practice of dentistry within California and have a familiarity of how claims and TARs are processed within the CD-MMIS. Scope of knowledge and skill are defined to include, but not limited to: knowledge of the Medi-Cal Dental Program's regulations, policies, procedures; beneficiary and provider complaint processes; and public contact experience, either direct or telephone contact. The knowledge and skill requirement may be met through applicable work experience, being a licensed dental paraprofessional, or by attending Medi-Cal dental program training courses administered by the Contractor prior to being assigned to the beneficiary TSC;

2) Ensure beneficiary TSC staff has access to a consolidated beneficiary database that contains all necessary information required to fulfill the Contractor's responsibilities, including open and closed beneficiary complaints/grievances, fair hearing cases; scheduling information on clinical screenings; dental provider referral file; and information regarding the notification to beneficiaries whenever services that require prior authorization is denied or modified. There shall be sufficient computer resources to fully support toll-free telephone line activities and associated administrative support activities;

3) Maintain sufficient beneficiary TSC staff for the toll-free lines, however, the Contractor may direct the beneficiary toll-free telephone lines staff to the provider toll-free telephone lines and visa versa (with Department approval) to better meet the needs and demands of beneficiaries and providers. A "P" factor of no more than seven percent (7%) shall be maintained;

4) Ensure beneficiaries shall be notified of the toll-free telephone number(s) and the hours during which the toll-free lines are operational. All incoming lines must use an automatic call distributor to allow calls to be handled on a "first (1^{st}) in, first (1^{st}) answered" basis when all operators are busy and maintain a "P" factor of no more than seven percent (7%);

5) Ensure beneficiary TSC is operational and staffed between the hours of 8:00 a.m. and 5:00 p.m., PST, Monday through Friday, excluding State holidays, and shall have a dental consultant accessible for consultation and/or to assist the operators in speaking with the beneficiary and/or their dental provider; and after regular business hours, provide an automated message system to collect caller information (e.g., voice mail).

6) Ensure there shall be management personnel to supervise telephone operations; perform direct liaison activities with Department personnel; and sufficient clerical and administrative staff to meet toll-free telephone operational needs;

7) Ensure the beneficiary TSC system unscheduled downtime does not exceed one-half hour for any given month. In the event of system failure the Contractor shall:

   a) Notify the Department of any incident of beneficiary toll-free telephone lines downtime within one hour of the incident, or as soon as the Contractor is aware of the interruption. As soon as the cause and projected duration of the unplanned interruption is known, the Contractor shall provide that information immediately to the Department;

   b) Within twenty-four (24) hours of the systems repair, notify the Department in writing of the actual cause, all areas impacted, the measurements taken to correct the problem and what additional measures have been put into place to prevent the problem from reoccurring;

   c) Provide an electronic notice to applicable Contractor staff and the Department of any planned system interruption, shutdown, or file non-access, at least three (3) State workdays prior to the system interference;

   d) Ensure that staff can adequately address the call volumes in order to meet performance requirements. (Historical call volume details can be found in the Data Library during the procurement process); and

   e) Ensure beneficiary TSC staff possess knowledge of claims processing background and good customer service skills to resolve complex problems (e.g., knowledge of the Medi-Cal Dental Program's regulations, policies, procedures).

8.4.1.2 BENEFICIARY TELEPHONE SERVCE CENTER OPERATOR RESPONSIBILITIES

The Contractor shall:

1) Assist beneficiaries to gain access to Medi-Cal dental providers who will provide them with medically necessary dental services. All provider referral requests are to be responded to the same day, if possible, but not more than five (5) State workdays from initial request. All referrals shall be confirmed in writing and mailed to the beneficiary within five (5) workdays from the initial request. If limited provider access is identified, this information shall be forwarded to the Contractor's provider outreach function within five (5) State workdays;

2) Upon receipt, resolve, and respond to beneficiary complaints, grievances and general inquires related to the Medi-Cal Dental Program, i.e. CCS/GHPP, CMSP, CHDP Gateway, CTP, HF, within the timeframes previously stipulated;

3) Redirect beneficiary inquires unrelated to the Medi-Cal Dental Program to other resources (i.e. other state or federal agencies, Dental Board of California, Department of Health Services);

4) Provide clarification to beneficiary inquiries regarding notification of a denial or modification of a requested service(s) requiring prior authorization which shall include an explanation of the applicable program criteria;

5) Provide clarification to general inquiries related to Share-of-Cost and/or co-payment requirements applicable to Medi-Cal dental services;

6) Provide clarification or refer to appropriate staff those inquiries related to dental fair hearing issues;

7) Provide assistance to Spanish speaking beneficiaries;

8) Refer complex inquiries, to the correspondence and research staff or other appropriate staff for more complete and extensive research;

9) Ensure the beneficiary TSC meet or exceed the following:

    a) The weekly average number of incoming calls that are blocked (calls receiving a busy signal) shall be no more than seven percent (7%); i.e. the "P" factor;

b) The weekly average abandon rate shall be no more than seven percent (7%). A call will be considered abandoned when a caller chooses to disconnect after the introductory message and prior to being connected to an operator or voice mail;

c) The weekly average wait or hold time shall not exceed sixty (60) seconds;

d) All calls must be answered within three (3) rings (a call pick-up system that places the call in queue may be used);

e) Execute all Department requests for temporary phone messages within twenty-four (24) hours of the request; and

f) All voicemail calls shall be returned within one (1) business day.

10) Provide computer telephony equipment for the beneficiary toll-free telephone lines which includes the following technology:

a) A PBX switch and all required hardware needed for Computer Telephony Integration (CTI). The switch must allow integration with other technologically advanced systems;

b) Equipment required to achieve operational requirements;

c) Management of call traffic through the use of computer-based systems;

d) CTI equipment must allow for future upgrades and additions of current computer telephony applications;

e) On-line, real-time interactive server capable of serving all beneficiary toll-free telephone lines, staffing and supervisors;

f) Beneficiary toll-free telephone lines support of interconnectivity among the various call center activities under the beneficiary toll-free telephone lines umbrella; and

g) TDD phone line(s) to provide services to hearing-impaired beneficiaries.

8.4.2 BENEFICIARY CLINICAL SCREENING PROVISIONS

The Contractor shall:

1) Conduct screenings at a reasonable time and in a place that is reasonably accessible to beneficiaries. “Reasonably accessible” shall be defined herein as follows:

   a) Beneficiaries shall not be required to wait more than one (1) hour beyond the scheduled time of their screening appointment;

   b) Screening appointments shall be scheduled during the normal working hours of the clinical screening dentist. However, special scheduling accommodations shall be made available to beneficiaries based on needs stemming from, but not limited to, disability, required travel time to the screening site, transportation, employment hours, or child care needs;

   c) No beneficiary shall be required to travel more than:

      i. Thirty (30) minutes to the screening site in urban/suburban areas;

      ii. Ninety (90) minutes to the screening site in rural areas;

      iii. No private residence (beneficiary’s or screening dentist’s) screenings shall be allowed.

2) Provide on-site screening visits to institutionalized beneficiaries, e.g., nursing homes, convalescent homes, or any State licensed facility;

   The clinical screening dentist arranges these types of screenings. It is the screener’s responsibility to contact the facility and schedule a time to conduct the examination;

3) Send a letter to the facility, notifying them that the patient will have a screening examination performed. Also, the Contractor shall send a screening informational packet to the clinical screening dentist the same day the letter is sent to the facility. Upon completion of the screening, the clinical screening dentist shall return all packets to the Contractor within forty-eight (48) hours of the examination;

4) Appointments for clinical screenings are scheduled and beneficiaries are notified of appointments within eleven (11) calendar days of the determination that a clinical screening is needed;

5) A clinical screening appointment is scheduled within three (3) weeks and the beneficiary is notified;

6) Maintain records of all complaints received from beneficiaries, the nature of the complaint, and the Contractor's action to resolve the complaint. (Upon request this information shall be made available for Department review);

7) Provide beneficiaries or their authorized representative with assistance in rescheduling and/or canceling clinical screenings and respond to questions/concerns regarding the screening process;

8) Reschedule the clinical screening if the beneficiary notifies the Contractor that he/she is unable to make the scheduled appointment. The screening shall be rescheduled at a time and place that is mutually acceptable to the beneficiary and the clinical screening dentist;

9) Schedule one (1) further clinical screening appointment if the beneficiary fails to keep the scheduled appointment, or if the beneficiary notifies the Contractor of a scheduling difficulty. The clinical screening dentist shall notify the Contractor within two (2) calendar days of the missed appointment. The Contractor shall keep a log and all correspondence of notification from the screening consultant and make the information available to the Department within two (2) State workdays of the Department request;

10) Ensure the clinical screening dentist examines the beneficiary and renders his/her findings in a written report of the clinical examination based on professionally recognized standards of care; and

11) Ensure whenever the clinical screening dentist cancels the screening appointment, and if the Contractor is unable to notify the beneficiary prior to the beneficiary appearing for the appointment, the beneficiary shall not be required to wait for a reschedule nor shall the services be denied, modified or delayed based upon the failure of having a screening. However, if the Contractor is able to reach the beneficiary in advance of the scheduled appointment, the appointment shall be rescheduled at the beneficiary's convenience.

8.4.3 BENEFICIARY COMPLAINTS AND GRIEVANCES

The Contractor shall:

1) Ensure beneficiaries and/or their authorized representative have the ability to file a complaint/grievance via the toll-free telephone number or by written communication. Complaints received by the Department may be referred to the Contractor for research and resolution;

2) Ensure all complaint/grievances are acted upon within three (3) State workdays of receipt and shall be resolved within thirty (30) calendar days of receipt;

3) All complaints/grievances are acknowledged and responded to in accordance with the Knox-Keene requirements;

4) All involved parties are contacted to ascertain relevant facts. If the complaint involves quality of care concerns, the Contractor may refer the beneficiary for a second opinion clinical screening to determine if the complaint has merit. If the quality of care complaint is determined to have merit, a referral of the provider's name, provider ID number, the nature of the complaint, and the results of the complaint investigation shall be made within five (5) State workdays to the Department and to the Dental Board of California. Consideration shall also be given as to whether a referral to the Contractor's S/URS operation is appropriate;

5) When a complaint (provider or beneficiary) involves a referral that is within the Contractor's scope of responsibility, the Contractor shall conduct its own investigation and complaint resolution and shall notify the Department as stipulated under the S/URS and/or QM requirements;

6) If the Contractor is unable to resolve a complaint/grievance and the beneficiary's issue involves a denial or modification of service authorization resulting from a submitted TAR, the beneficiary shall be informed of their right to a State fair hearing and where to file such a request in accordance with Title 22, California Code of Regulations, Section 50951(a);

7) Anonymity of the complaint shall be offered and, if requested by the beneficiary or their representative, such anonymity shall be protected. The beneficiary or their representative shall be informed that such anonymity cannot be guaranteed in the case of the Department, or other duly authorized federal/state representatives, who may access the records of the Contractor;

8) An individual record of all complaint/grievances received is to include the following:

    a) Date complaint/grievance was received and whether received in writing, by telephone, or in person;

b) Beneficiary's name, address, phone number, social security number, and name, address and telephone number of authorized representative, if applicable;

c) Log number of the complaint;

d) Name, address and provider number of involved provider if complaint involved quality of care issues by a particular provider;

e) Related complaints and their log numbers (related by the fact that the same beneficiary has another complaint(s), the complaint is about the same provider, etc.);

f) Nature of the complaint;

g) Actions taken to research, resolve and respond to the complaint with such information listed by date of action;

h) Name of provider referral(s) given and date of such referral(s);

i) Resolution and the date such resolution was achieved; and

j) Date(s) acknowledgment/resolution notice(s) sent to the beneficiary to ensure compliance with Knox Keene requirements.

9) The resulting complaint/grievance records are retained for a period of five (5) years or for the term of the contract, whichever is longer and all such records made available to the Department or duly authorized federal/State representatives, upon request.

8.4.4 TREATMENT AUTHORIZATION REQUEST (TAR) NOTIFICATION

The Contractor shall:

1) Establish and maintain staff to respond to beneficiary or authorized representative inquiries regarding notifications received informing them that dental services requiring prior authorization were either denied or modified.

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2) Ensure written notifications are generated when one (1) or more of the service lines on a TAR, a Notice of Authorization (NOA), or a Request Turnaround Document (RTD) required

prior authorization as a condition to payment, and such service line(s) was denied or modified. (Use of the replace and substitute procedures are considered modification of a TAR).

8.4.5 DENTAL FAIR HEARINGS

The Contractor shall respond to beneficiary inquiries received through the beneficiary TSC that are associated with dental Fair Hearing (FH) issues and will prepare a fair hearing position statement to include, but not limited to:

1) The primary issues(s) involved in the case;

2) A simple statement as to the Department's position on the issue(s) cited and the regulatory basis for taking that position;

3) The facts in the case:

   a) When the Treatment Authorization Request (TAR) was received;

   b) Who evaluated the TAR;

   c) What was the disposition of the case and why;

   d) What else happened (i.e., telephone conversations, correspondence, x-rays received, clinical screening examinations, etc.); and

   e) Include as attachments, copies of documentary evidence and attach these as the exhibits.

4) If applicable, a statement regarding the provider's responsibility in regard to the reason the services were denied; and

5) Declaration.

8.4.5.1 INCOMING MAIL

The Contractor shall, on a daily basis, perform the following tasks associated with incoming FH mail:

1) Open envelopes, date stamp contents, assign case number (when applicable), create hardcopy case file folders for new cases, scan and verify that all data is entered correctly,

make photocopies of the incoming documents, and make applicable corrections to the FH database;

2) Log incoming FH requests onto the Department's FH database;

3) Forward original FH requests, using interdepartmental envelopes, to the State Department of Social Services;

4) Deliver new FH requests and other related documents received on all FH cases that are in process to the Contractor's staff for processing;

5) Prepare and mail out a letter requesting information for Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) evaluation to the treating dentist on all orthodontic related cases;

6) Date stamp incoming final FH decisions, scan decisions onto the Department's FH database, update and verify that all scanned information is accurate; and deliver internally within the Contracting Officer's operation; and

7) Ensure all incoming diagnostic information associated with a case is logged, scanned and delivered immediately to appropriate Department staff.

8.4.5.2 FAIR HEARING POSITION STATEMENTS AND CONDITIONAL WITHDRAWALS

Under the Medi-Cal Dental Program the beneficiary has the right to a fair hearing if he/she disagrees with the decision to deny and/or modify requested dental services. During the fair hearing process the beneficiary has the right to make their appeal to an Administrative Law Judge (ALJ) as provided through the Department of Social Services (DSS).

A Position Statement (PS) addresses the merits of each case by substantiating the Departments decision to deny and/or modify requested dental services (i.e., outside the scope of Title XXII, not a covered benefit or not considered the least cost beneficial treatment). Each PS cites the appropriate regulatory requirement that relates specifically to the treatment request and supports the original adjudication decision.

The approved PS is provided to both the beneficiary and ALJ prior to the hearing and replaces the need for Department staff to attend each hearing. However, Department staff are required to be available by telephone and testify at each hearing if requested by either the beneficiary or judge.

The Contractor shall, upon receipt of a new FH request, complete the following tasks within thirty (30) calendar days of the receipt of such request:

1) Using the S/URS CDR function in CD-MMIS, enter the beneficiary's primary social security number to verify subsequent TAR/Claim/NOAs or any incoming documents that may be pertinent to the fair hearing case.

2) Provide copies of all documents relevant to the service(s) at issue in each fair hearing case, including but not limited to:

   a) TARs;

   b) Claims for Payment;

   c) CD-MMIS screen prints;

   d) Applicable grievance/complaint records and relevant provider appeal documentation;

   e) Pertinent correspondence that may be retained in the provider's file maintained by the Contractor;

   f) Pertinent Beneficiary Services "call log" information; and

   g) Proof of date denial notice sent.

3) Substantiate a written analysis of the dental services at issue in each fair hearing case, which shall also include a summary to be called "finding(s)". In the analysis, specific reference is made to the Document Control Number (DCN) that substantiates the adjudication and reason(s) for denial or modification and or the reason(s) why provider payment was not issued, if applicable. There shall be a chronological listing of events to include, but not limited to:

   a) Date provider requested service(s);

   b) Date TAR and/or Claim received;

   c) Date TAR and/or Claim adjudicated; and

   d) Date denial notice sent.

4) The "Findings" portion of the position statement shall include a substantiated analysis of the original adjudication. Following are requirements that must be performed to develop a substantiated analysis:

a) For all cases involving denial of dentures (full or partial), relines, treatment plans for five (5) or more crowns, or when the denial reason was based on an incomplete treatment plan being submitted by the provider, the Contractor shall schedule the beneficiary for a second opinion clinical screening, unless a screening has been conducted within the past four (4) months. The screening dentist shall not be the last screener of record to examine the patient. When screenings are required to substantiate the Contractor's position on the service(s) at issue, screening appointments shall occur within eleven (11) calendar days from date of receipt of the FH request;

b) If the beneficiary fails to attend the first (1st) screening, the Contractor shall contact the beneficiary (by telephone, or by letter if no telephone access) to determine why they failed to appear. The Contractor shall automatically schedule a second screening within two (2) weeks and notify the beneficiary accordingly. Failure to appear for the first (1st) screening appointment and any reschedule information shall be documented by the Contractor staff in the fair hearing data base "comments" section. This information shall also be documented in the position statement analysis to uphold the original modification or denial of dental services;

c) For FH cases where the services at issue were denied based on radiographs that accompanied the initial TAR, the Contractor shall prepare a written request to the provider (using State letterhead) requesting resubmission (within five (5) calendar days from receipt of the Department's letter) of the radiographs for reevaluation. This written request to the provider shall be completed within ten (10) calendar days of receipt of the FH request. If the provider's response/radiographs are not received within ten (10) calendar days of the Department's request, the Contractor shall, on the eleventh (11th) calendar day make one (1) follow-up call to the treating provider's office to speak with an individual to determine the status of the request. Leaving a voice mail message is not acceptable; and

d) Upon receipt, or non-receipt of the requested radiographs, or the Screening Dentist's report, the Contractor shall determine which of the following substantiated actions to take:

i. Grant Dental Services At Issue:

The Contractor shall contact the claimant (beneficiary) or their authorized representative, inform them of the proposed decision related to their FH, and attempt to secure concurrence from the claimant to withdraw the request rather than to go forward with an actual fair hearing. (Hereafter referred to as a "Conditional Withdrawal.")

1. Claimant agrees to withdraw their hearing request:

   The Contractor is to provide the claimant with the Department of Social Services' toll free telephone number to call and cancel their hearing request. The Contractor shall prepare authorization letters to the beneficiary, on State letterhead, using pink, white and green authorizing the requested service(s) at issue and forward such letters for signature to the contracting officer or designee for review and approval. The Contractor shall at the same time process all pended claim\TARs for the claimant (beneficiary).

2. Claimant does not agree to withdraw their hearing request:

   If the Contractor is unable to contact the claimant by phone, or if the claimant does not agree to withdraw the case, the Contractor shall annotate the telephone conversation, or lack thereof, in the fair hearing database, prepare, and forward a position statement to the Department for review and approval.

ii. Grant a Modification of Dental Services at Issue:

Contractor's dental consultant shall contact the treating dentist and discuss the proposed change. If the treating dentist concurs, the consultant annotates this information in the fair hearing database; next the Contractor must contact the claimant to discuss the change in treatment.

1. Claimant is in agreement:

Contractor prepares/routes a conditional withdrawal letter as described above.

2. Claimant disagrees:

This information is entered in the "comments" section of the Department's Fair Hearing database. A fair hearing position statement is prepared by the Contractor then forwarded to the Department for review and approval. All radiographs, screening reports, and/or other documentation used by the Contractor in concluding an alternate treatment plan was appropriate, shall accompany the position statement when transmitted to the Department.

iii. Uphold the Original Denial:

The Contractor shall prepare and submit to the Department a position statement explaining the basis for such determination/conclusion. All applicable radiographs, screening reports, and/or other documentation used to substantiate this conclusion must accompany the position statement when submitted to the Department for review and approval.

5) Distribute Department approved position statements or conditional withdrawals at least one (1) week prior to the scheduled fair hearing.

8.4.5.3 FAIR HEARING DATABASE FILE MAINTENANCE

On a monthly basis, the Contractor shall archive all Department maintained FH case files where there is written notification that provider payment(s) have been issued on the service(s) at issue as follows:

1) Access the appropriate case file on the Department's Fair Hearing Database, verify all required data fields are complete, if not, input missing data;

2) Add the method of closure (i.e., payment, denial); and

3) Annotate in the comments section that the case is being archived.

8.5 ORGANIZATION AND STAFFING GENERAL RESPONSIBILITIES

The Contractor shall employ qualified staff to perform Beneficiary Services duties/responsibilities that shall include a corresponding compliment of management/supervisory personnel, and administrative/clerical support staff. Management/supervisory personnel shall be utilized to control work activities, assign priorities, attend planning/problem resolution meetings, and monitor daily operations to ensure contractual compliance. Selected functions have specific requirements, limitations on work activities/locations, and/or time requirements for filling vacant positions. All Beneficiary Services staff shall be provided with necessary computer resources, equipment and materials that are necessary in the performance of their assigned activities. This shall include the ability to speak to a Dental Consultant Monday through Friday 8:00 a.m. to 5:00 p.m., PST, excluding State holidays, as necessary to address/resolve clinical related issues/complaint, fair hearings, patient screenings, etc.

1) Staffing Requirements:

   Staffing shall be provided at the levels and numbers as deemed necessary to ensure the Contractor performs all contract requirements associated with the following:

   a) Beneficiary access to Medi-Cal dental providers;

   b) Beneficiary complaints/grievances;

   c) Beneficiary correspondence and denial notifications;

   d) Dental Fair Hearings;

   e) Beneficiary Telephone Service Center (TSC) Operations; and

   f) Clinical Screenings

8.6 REPORTING REQUIREMENTS

The Contractor shall:

On a monthly basis submit a summary report to the Department on the following Beneficiary Services activities. This report shall categorize data by the following five (5) major subjects listed below and with the resulting report being on-line accessible to Department staff as well as the Contractor's Beneficiary Services staff:

1) Beneficiary inquiries for dental provider referral;

2) Beneficiary complaints, grievances, and fair hearings;

3) Beneficiary denial and/or modification of dental service notifications;

4) Beneficiary inquiries on second opinion clinical screenings; and

5) Beneficiary telephone service center busy rate, abandon rate, average wait time, and voice mail return rate.

This report shall give the number of contacts received by category; the type of contact (toll-free telephone or written communication); the information sought or the complaints received by summary categories that have been prior approved by the Department; the mode, mean, and median span of time (in calendar days) from the initial contact with the beneficiary or their authorized representative until resolution of the situation has occurred; and what the Contractor did to provide assistance.

The Contractor shall establish and maintain daily logs and specific documentation to gather the source data for this summary report. All such logs and supporting documentation shall be made available to the Department upon request.

8.7 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Review and approve the Beneficiary Services Manual, and all replacement updates prepared by the Contractor prior to release;

2) Develop, clarify and provide guidance on policies and procedures related to Beneficiary Services;

3) Review and approve all materials sent to beneficiaries;

4) Approve CD-MMIS forms utilized by Beneficiary Services with the Medi-Cal Dental Program, prior to distribution;

5) Review and approve Contractor procedures for telephone and correspondence responses, and any change thereof;

6) Review, and approve CD-MMIS system modifications as they relate to Beneficiary Services;

7) Review and approve staffing changes within the Beneficiary telephone service center operation; and

8) Provide policy guidance on dental fair hearing operations.

9.0 NON-MAINFRAME SYSTEMS

9.1 OVERVIEW

The non-mainframe systems are critical to the success of the CD-MMIS claims payment process, and are an integral part of the running operations of the CD-MMIS in addition to the subsystem activities performed on the CD-MMIS mainframe. It shall be the responsibility of the Contractor to provide the on going operational and maintenance support for all non-mainframe systems in existence, or those to be developed during the existence of this contract in order to meet contractual requirements.

The known non-main-frame entities to support CD-MMIS are detailed in Exhibit A, Attachment II, Operations, Interactive Voice Response System; Services Tracking Analysis and Reporting System; and Document Imaging Management System sections.

9.2 OBJECTIVES

Objectives of the Non-Mainframe systems are to:

1) Quickly provide information required for review, development, monitoring and regulation of dental policy;

2) Monitor claims processing activity and quickly provide summary reports;

3) Monitor beneficiary participation in order to analyze usage and develop needed programs;

4) Provide information required to monitor the delivery and utilization of covered services by Medi-Cal dental beneficiaries;

5) Provide information required to analyze and evaluate delivery and utilization of services on a case basis to guard against fraudulent and abusive use of the Medi-Cal Dental Program by either providers or beneficiaries and to identify those providers who provide services below the community standard of care;

6) Provide the Department with on-line access to all correspondence between the Department and the Contractor; and

7) Provide an interactive voice response system for providers and beneficiaries to access information regarding the Medi-Cal Dental Program.

9.3 CONTRACTOR RESPONSIBILITIES:

The Contractor shall:

1) Commit whatever resources are required to ensure that all systems are operational in order to meet all contractual requirements. This means that multiple staff may need to be assigned to troubleshoot and rectify problems in order to maintain acceptable levels of system outages. The Department anticipates the Contractor's Systems Group (SG) staff will provide support to the non-mainframe systems; and

2) Provide connectivity and support (e.g. providing administration of LAN workstations, troubleshooting hardware and software problems).

9.4 DEPARTMENT RESPONSIBILITIES:

The Department shall:

1) Notify the Contractor, in writing, of any changes needed in the non-mainframe systems; and

2) Provide support to the current Fair Hearing System (e.g. troubleshooting LAN/WAN connectivity, troubleshooting hardware and software problems, and provider server maintenance).

10.0 INTERACTIVE VOICE RESPONSE SYSTEM

10.1 OVERVIEW

The Interactive Voice Response (IVR) system enables callers (Medi-Cal dental providers, beneficiaries, and Clinical Screening Dentists) to communicate directly with an automated voice response system. The IVR system emulates human operators interfacing with telephone and computer terminals. It automates the functions of a telephone operator by speaking to the caller in a recorded digitized human voice. It also automates the function of a computer terminal operator, enabling the caller to access specific types of information stored in the computer. The IVR system uses touch-tone functionality using Dial Tone Multi Frequency (DTMF) tones to migrate through the application.

10.2 OBJECTIVES

The Objectives of the IVR system are to:

1) Efficiently manage a large number of incoming telephone lines and calls;

2) Provide Medi-Cal dental providers access to the following information:

    a) Billing criteria information;

    b) Seminar information;

    c) News flashes;

    d) Request for forms to be faxed:

        i. Medi-Cal Dental Program forms;

        ii. Clinical Screening Dentist application forms;

        iii. EDI application forms;

        iv. Billing criteria/scheduled maximum allowance information; and

        v. Billing intermediary forms.

    e) Specific claim information (requires Document Control Number (DCN)):

        i. Amount;

ii. Status; and

iii. Applicable EOB date and allowed amount.

f) Specific information on a specific beneficiary (requires beneficiary's social security number (SSN)):

i. Status of outstanding claims and/or TARs submitted;

ii. Information on beneficiary's last three claims.

iii. Check number;

iv. Claim amount;

v. DCN;

vi. Last action taken;

vii. EOB Date; and

viii. Beneficiary's history (relative to specific service limited procedures).

g) Financial information (requires an authorized Personal Identification Number (PIN)):

i. Next provider check amount;

ii. Year to date earnings; and

iii. Year to date earnings for the previous year.

3) Provide beneficiaries access to the following information:

a) Request provider referrals using zip code and SSN;

b) Option to re-schedule or cancel a screening appointment; and

c) Submission of complaints.

4) Provide Clinical Screening Dentists access to immediately reach the appropriate telephone representative.

10.3 ASSUMPTIONS AND CONSTRAINTS

1) The current system is a forty-eight (48) port T1 Vista system (includes an additional four (4) port development area);

2) The IVR system shall be available twenty-four (24) hours, seven (7) days a week for information that does not require a provider number;

3) The IVR system shall be available the following hours for information requiring a provider number, service office and/or PIN:

   a) 6:00 am – 5:30 pm Monday – Friday

   b) 8:00 am – 12:00 pm Saturday

4) Beneficiaries shall have access to the IVR system by calling a separate toll-free line. A Spanish-speaking option shall be provided; and

5) The Automated Eligibility Verification System (AEVS) will be available to providers to only obtain eligibility information for beneficiaries enrolled in the Medi-Cal Dental Program. (AEVS is supported and maintained by the fiscal intermediary responsible for Medi-Cal medical claims processing.) Providers enter the beneficiary identification number taken from the beneficiary's Benefits Identification Card (BIC).

10.4 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Maintain and update the IVR system to incorporate new messages, new system software, and new applications for improvement to the system as instructed by the Department;

2) Support and maintain all hardware and software necessary for the operation of the IVR system;

3) Order, install, maintain, and support all telecommunication lines necessary for the support of the IVR system;

4) Provide assistance with problems and questions related to the use of the different types of IVR system transactions;

5) Update and disseminate the IVR User Guide;

6) Provide advance electronic notice to the Department of any planned system interruption, shutdown, or file non-access. If an unanticipated interruption should occur, a notice shall be

sent to the Department as soon as the Contractor is aware of the interruption. When the Contractor learns of the cause and projected duration of the unplanned interruption, the Contractor shall immediately provide that information to the Department, in writing;

7) Notify the Department within twenty-four (24) hours of completing system repairs, the cause of the problem, all areas impacted, the measurements taken to correct the problem, and all additional measures taken to prevent the problem from reoccurring; and

8) Maintain all IVR system files and reports.

10.5 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Monitor and evaluate the accessibility to Medi-Cal dental providers and beneficiaries through reports generated by the IVR system; and

2) Evaluate utilization of Medi-Cal dental providers and beneficiaries accessing the IVR system.

11.0 SERVICES TRACKING ANALYSIS AND REPORTING SYSTEM

11.1 OVERVIEW

The Services Tracking Analysis and Reporting System (STARS) is an existing automated problem identification system. STARS quickly obtains custom designed reports using any CD-MMIS data element and allows creation of data warehouse in a client server environment to produce data reports. Detail claims analysis can be performed from a PC workstation in a matter of minutes based on the precise criteria selected. Data may be repeatedly queried, organized, ordered, counted, filtered, mapped, profiled, ranked, sampled, trended, or displayed as determined by the requestor. STARS can quickly provide user specified reports using claims processing data from CD-MMIS.

11.2 OBJECTIVES

The following are the objectives of STARS:

1) Create standard queries such as: sorting each provider by dollars paid, percent of change in previous payments, and number of unduplicated beneficiaries;

2) Facilitate fraud and abuse research. Identify inappropriate utilization or aberrant billing patterns;

3) Identify dental policy issues;

4) Identify shortcomings in prepayment edits;

5) Generate ad hoc reports;

6) Allow for Department contract monitoring;

7) Perform Special Performance Reviews (SPR) and special Quality Management studies;

8) Provide information gathered on the selected providers concerning procedure codes, shared unduplicated beneficiaries, geographic area dates of service, and beneficiary samples; and

9) Enable the use of geographic mapping capabilities to evaluate access to dental care in any part of the State. The location of participating providers (by user-selected criteria) can be plotted on maps of a specified region to help identify under-served areas or other factors that restrict beneficiary access to care. The mapping function also supports the

scheduling of Clinical Screening appointments by providing information on the distance a beneficiary would have to travel to be seen by any given Clinical Screening Dentist.

11.3 ASSUMPTIONS AND CONSTRAINTS

1) The current hardware consists of the following:

   a) Hewlett Packard 9000 K360 server with two (2) CPUs;

   b) Hitachi Data Systems 5744 – 69GB RAIDS disk array; and

   c) Hewlett Packard Pentium II PCs with 17" monitors.

2) The current software consists of the following:

   a) Sybase Adaptive Server Enterprise;

   b) Sybase Open Server;

   c) Open Client/C Developer's Kit;

   d) SQL Backtrack;

   e) Connect: Direct for Unix;

   f) Platinum Utilities;

   g) Best/1 for Distributed Systems;

   h) Map Info Professional 5.0 for Windows NT (includes Crystal Reports);

   i) Map Info Street Info;

   j) MapInfo County Boundaries; and

   k) Symantec PC Anywhere 32, version 8.

3) Each month, various extract files are created out of the mainframe files; some of these files are, in turn, processed through programs that perform reformatting of the data for upload to the STARS database with the other files routing directly to the database;

4) Claim information is extracted from CD-MMIS using the paid date as one of the selection criteria;

5) NOA and TAR information are extracted from CD-MMIS after being completely adjudicated using the adjudication date as one of the selection criteria;

6) Provider data is extracted from the Provider Master File and Provider Sanctions File;

7) Beneficiary data is extracted from the State FAME Monthly Extract File; and

8) STARS server is currently at sixty-four (64) gigabytes.

11.4 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Ensure the provider, beneficiary, and claims data are extracted and uploaded into the STARS database within twenty-four (24) hours of the completion of the last weekly claims processing cycle for the month;

2) Maintain the STARS database and provide on-going support and respond to staff questions during normal business hours;

3) Provide the necessary platform for intelligent storage that complements the querying and reporting tools composed with Power Builder;

4) Extract claims data that contain paid and denied claims on a monthly basis;

5) Extract NOA and TAR data after final adjudication;

6) Extract provider data from the Provider Master File on a monthly basis;

7) Extract and maintain beneficiary data from the FAME File on a monthly basis;

8) Maintain a rolling minimum three (3) years of data;

9) Provide enough server space for future additional data elements;

10) Provide one (1) workstation located at the Department's user's site. This workstation shall provide access to STARS including monitor, printer and any related equipment. Equipment must be equivalent to the equipment used by the Contractor;

11) Submit a change instrument to request addition or deletion of data elements for Department approval; and

12) Submit a change instrument to request system modifications and/or enhancements for Department approval.

11.5 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Submit a change instrument to request addition or deletion of data elements;

2) Submit a change instrument to request system modifications;

3) Own all STARS data, queries, and reports; and

4) Retain all disk space at the end of the contract.

12.0 DOCUMENT IMAGING MANAGEMENT SYSTEM (DIMS)

12.1 OVERVIEW

To improve the overall efficiency of the CD-MMIS operations, the Contractor shall design, develop, and install a Document Imaging Management System (DIMS) to provide all Medi-Cal Dental Program documentation to be stored and managed online. The DIMS will be accessed through an Intranet site to allow the Department and the Contractor staff access to the CD-MMIS documentation. CD-MMIS documentation includes formal correspondence between the Department and the Contractor, provider manuals, dental operating instruction letters, the RFP, problem statements, system development notices and their associated documentation; (i.e., SFD/TSD/Testing/E&T/IMP/PIR), move sheets, supplemental processing guidelines, work requests, include members, program source code, and SYSIN members, and specific production reports (per Department instructions). DIMS is thus, an electronic library.

12.2 OBJECTIVES

1) Convert hardcopy pages to an electronic format;

2) Improve Problem Statement (PS) tracking by utilizing a workflow tool;

3) Reduce time required to maintain documentation;

4) Improve accuracy and accessibility of documentation;

5) Complete data element to program cross-reference capability;

6) Have the ability to index documents ranging from provider manuals to personal faxes;

7) Provide library and security control services;

8) Provide extensive search capabilities including file attributes and full text;

9) Provide the ability to track multiple versions of the same document to provide a complete audit trail;

10) Provide for virtual document support which makes it easy to publish documents made up of many files;

11) All CD-MMIS source code would be copied into the system to take advantage of the full text search feature;

12) Provide the ability to view and edit the related CD-MMIS system documentation while editing a COBOL program in TSO; and

13) Ensure that the DIMS provides the ability to increase the number of system users without component replacement, support other technologies, support multiple servers, and symmetrical multiple processing.

12.3 ASSUMPTIONS AND CONSTRAINTS

The Contractor shall:

1) Begin the design and development of the DIMS required modifications to the CD-MMIS on the first (1st) year after the date the Contractor takes Assumption of Claims Processing;

2) Store all outstanding PS, SDNs, SFD/TSD/Testing/E&T/IMP/PIR, Change Orders, supplemental processing guidelines, work requests, include members, program source code, SYSIN members, and specific production reports transferred to the Contractor at the time of the Contract Effective Date;

3) Include the cost of the equipment, software, and peripherals for the DIMS in the bid. The Department will own the equipment used to support the CD-MMIS DIMS software;

4) Maintain a hardcopy document for every electronic copy document stored in the DIMS (e.g., for every formal correspondence letter stored in DIMS). An original signed hardcopy document will be stored in a hardcopy library and shall be available to on-site Department staff;

5) Provide a hardcopy of any document stored in the DIMS upon request. Users that have access to DIMS will produce their own hardcopy, but users that do not have access to DIMS may request a hardcopy from the Contractor;

6) Ensure the operation of DIMS shall have the capacity and capability to manage 50,000 documents per month;

7) Ensure work performed will be compensated in accordance with the Payment Provisions section. The design, development, implementation, and ongoing maintenance and operations of the DIMS is to be bid in the Contractor's

prices for adjudicated claim lines (ACLs) and Treatment Authorization Requests (TARs), and not the SG;

8) Minimize the possibility of any interruption in the provision of services to beneficiaries or in the payment of providers during this transition. The DIMS shall be implemented on a phased-in basis after the assumption of claims processing;

9) Ensure the technical proposal and price bid reflect a schedule that gives specific dates for each major task within the DD&I. When scheduling the work plan, allow a minimum of six (6) weeks for Department acceptance testing of the DIMS. These six (6) weeks shall be scheduled and receive Department approval prior to the time required to notify Medi-Cal dental providers of system installation; and

10) Should the Department or the Contractor choose to accelerate the implementation date(s) of the DIMS, the acceleration may be accomplished through mutual agreement of both parties. If the Department requires early implementation without Contractor agreement, this will be accomplished through the Change Order process. The Department reserves the right to cancel the DIMS at any time. After contract award and before work on the DIMS is scheduled to begin, the Department may terminate. In this case, the DD&I price will not be paid and, for the DIMS included in the Operations bid price, the operational impact will be considered through the Change Order process.

12.4 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Adhere to the design, development and implementation requirements outlined in the Contractor System Development Phase Responsibilities in the Change Requirement section;

2) Maintain DIMS and provide on-going support and respond to staff questions during normal business hours and perform on-going support that includes:

   a) Updates to the procedure manual;

   b) Availability for routine questions;

   c) Continual, as-needed, classroom instruction and handouts to increase the overall knowledge level of the DIMS software capabilities;

d) Instructions on using DIMS for routine research;

e) Daily tape backup;

f) User security assignments; and

g) Enforcement and maintenance of DIMS standards;

3) Ensure DIMS is available seven (7) days per week, twenty-two (22) hours per day, and has a maximum unscheduled downtime of one half (0.5) hour per week;

4) Provide training and training manuals/procedures to Department staff; and

5) Provide hands-on computer training to Department staff on the following general areas of DIMS (training requirements are described in Exhibit A, Attachment II, Operations, Staff Training Requirements):

a) Use of a search engine;

b) Check-in, check-out features;

c) Workflow;

d) Changes to current Contractor and Department procedures;

e) Customizing personal view;

f) Creating an alias;

g) Project Component;

h) Training on DIMS standards; and

i) Use of Change Agent.

6) Maintain a hardcopy library to store an original signed hardcopy document for every electronic copy document stored in DIMS. The hardcopy library shall be accessible to on-site Department staff during normal working hours;

7) Provide a monthly Exception Report to show any and all documentation that was not submitted within thirty (30) days of the system implementation date;

8) Extract all ++Include members into a pre-defined document format for use as the Data Element Dictionary (DED);

9) Download all COBOL programs and include members into DIMS to allow a cross-reference to be established between data elements, ++Include member and programs;

10) Maintain a database to reserve data element numbers and to incorporate and provide functionality of a Data Element Dictionary (DED) into DIMS. All COBOL program source code, copy books, and ++Include members will be downloaded into DIMS and pre-indexed. The Contractor shall ensure that the Search function has the ability to quickly produce a list of COBOL programs that access a given COBOL field name (tag name);

11) Provide standard procedures for update, review, and approval of the Medi-Cal Dental Program documentation and deliverables. The procedures will include a formal exception process to afford the Department the option to waive or postpone documentation when needed. The Department shall have system access that will allow these procedures to be audited from time to time to ensure that the DIMS software is being utilized to a satisfactory standard;

12) Ensure all Medi-Cal forms (i.e., Claims, CIFs, TARs, RTDs) screens, and reports are scanned and available electronically. As changes are made to these documents or forms, they shall be scanned and loaded into DIMS within two workdays of the change date to allow the user to reference the documents/forms currently used in production;

13) Ensure all formal correspondence is available electronically within five (5) business days of the release date published on the correspondence;

14) Utilize the Workflow tool to route and track the PS until completion. Within a workflow, information will be electronically routed through the Department and Contractor;

15) Download a copy of the COBOL source code for viewing in DIMS, when a program is moved into production;

16) Download a copy of any new production changes (e.g., ++Include members, SYSIN members, source code) to ensure all production changes are downloaded into DIMS on an on-going basis;

17) Utilize the search function to display all manual pages that may need to be updated or modified as a result of a Work Request (WR) or Dental Operating Instruction Letter (DOIL) requesting a CD-MMIS manual change;

18) Update the electronic manuals within thirty (30) days after a change is made to CD-MMIS;

19) Utilize and maintain Change Agent. Change Agent is a DIMS add-on module that allows e-mail notification of any changes in DIMS;

20) Maintain the DIMS procedure manual documenting how each process listed below interfaces with DIMS. The procedure manual shall contain the following:

    a) Descriptions of processes (e.g., SDNs, PSs, CD-MMIS manual updates);

    b) Pictures of new input screens;

    c) Description (graphical and text) of using Workflow for Medi-Cal processes;

    d) High level flowchart depicting link between manuals, ++Include members;

    e) Using Project feature of DIMS to aid in management of projects;

    f) Directory, naming, and timing standards; and

    g) Using Change Agent to notify staff of DOILS, FI letters, new SDN deliverables that have been added to DIMS, and when a specific manual has been updated.

21) Deliver reports to the Department in an agreed-upon format that document the design, testing, and installation of the accepted DIMS. These reports shall be presented in separate steps, to be individually approved for design, testing, and installation. The Contractor shall implement the DIMS and provide the following:

    a) Technical designs and user desk manuals;

    b) User training for department staff prior to implementation;

    c) On-site technical assistance during the implementation phase and continuing assistance throughout the term of the Contract; and

    d) Report to the Contracting Officer, in writing, any performance problems on the system, define the nature of the problem, the nature of the solution, and

describe any corrective measures to prevent the reoccurrence within a forty-eight (48) hour timeframe.

12.5 DEPARTMENT RESPONSIBILITIES

The Department shall review the deliverable reports and notify the Contractor if the deliverable is approved.

13.0 GENERAL REPORTING REQUIREMENTS

13.1 OVERVIEW

This section is intended to facilitate the identification of reporting responsibilities as well as to ensure consistent application of requirements for all CD-MMIS reports. Reports are defined as any compilation or reflection of data provided in any media including but not limited to hardcopy, compact disc (CD), microfilm, microfiche, on-line, tape, specific reports added to the CD-MMIS Library per Department instructions, or diskette, including Contractor data files. All reports produced by the Contractor, whether for internal or external use, shall conform to the requirements described in this Section unless otherwise specified in the contract. Internal reports are defined as any reports designed, developed, and installed by the Contractor for its use in managing its contract with the Department. All reports shall be subject to the terms and conditions set forth in this contract.

13.2 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Maintain a training and development program for appropriate Department and Contractor staff to ensure maximum use and understanding of all reports. Training shall ensure that users are able to interpret CD-MMIS reports to a degree that will allow for effective use. The Contractor shall provide a minimum of six (6) training sessions each State fiscal year. Four training sessions shall be limited to Department staff only, but the Contractor shall provide the Department access to all training sessions and notify the Department of all training sessions fifteen (15) calendar days in advance of the scheduled date. This training shall be in addition to all other training required by this contract;

2) Ensure that at least one (1) staff person is available from 8:00 a.m. to 5:00 p.m. PST, Monday through Friday, to perform general reporting staff liaison activities. The primary responsibilities shall be to assist the Department by performing the following reporting functions:

   a) Data processing;

   b) Database development/maintenance;

c) Statistical and research reporting;

d) Report production and delivery;

e) Research/report problem solving activities;

f) Report accuracy and data validity; and

g) Development of techniques to obtain more effective and efficient use of CD-MMIS data by the Department.

3) Provide suggestions to the Department that could enhance reporting. Suggested changes may include elimination or creation of reports, modifications to report format, data elements, production frequency, medium, or data descriptions. Starting no later than fourteen (14) months after contract effective date, and by the end of each calendar year, the Contractor shall produce an annual report for Department review and approval that lists recommended improvements to CD-MMIS reporting;

4) Maintain report user manuals subdivided by subsystem, for all CD-MMIS reports. The documentation in the manuals shall be subject to the Data Processing and Documentation Responsibilities requirements and shall consist of the following items:

a) All reports must use a standard report heading;

b) The report definition/description, which includes a brief statement of purpose, a detailed description and definition of report elements, the report number (which relates to the detail design documentation), the report name, the program that produced the report, balancing routines, control and audit functions, report frequency, report medium, and report distribution;

c) A report content listing of the data elements and/or report elements used and describing the data calculations performed, sequence of the report, and estimated volume based on the most recent information available. If a report element is not defined in the CD-MMIS documentation, the Contractor shall define the report element in the Report Users Manual and use a standard report heading;

d) User procedures and interfaces;

e) An example of the produced report showing all data items, summary total data, and all representative formats within the report;

f) A composite listing of all reports by subsystem showing the report number, report name, producing program, frequency, distribution, and report retention period;

g) Identify when the report is a functional equivalent to a required report. In addition, this listing shall identify all reports for which the Department has waived production requirements, and provide an audit trail with reference (Department Correspondence Number and Date) to the Department's approval of each functional equivalent and waiver; and

h) Include any cross-reference to other corresponding reports that support summary totals or data.

5) Maintain the Reports Distribution List for all CD-MMIS reports. This list shall include:

a) Report name and report number;

b) Report description;

c) Report frequency;

d) Number of copies produced and their destinations*;*

e) Bursting and/or collating instruction, and other information deemed necessary;

f) The medium and/or media in which the report(s) is/are currently produced; and

g) Special instructions.

6) Maintain the Reports Distribution List in two (2) sequences, one (1) by user (the person who receives the report) and the other by report number. The Contractor shall provide updates of this report within two (2) weeks of receipt of a Contracting Officer change request. Updates shall occur each time any report/user information is changed, added or deleted;

7) Organize and maintain on microfiche or electronic media, a Master Library of all reports produced including the Contractor's internal reports but excluding data files, S/URS Claim Detail Reports (CDRs), and Aged History Reports (AHRs). This Library must be located at the site of the Contractor's Operations. Reports shall be available in the Master Library within eight State workdays after report

production. This Library shall be accessible to Department staff during State workday hours;

8) Provide the Department with access to or delivery of copies of all Contractor-produced reports, whether for internal or external use, within forty-eight (48) hours of request by the Contracting Officer. If the report is older than twelve (12) months or larger than fifty (50) pages, it shall be provided within five (5) State workdays;

9) Participate in or perform statistical and/or research studies and reporting as the Department may direct or approve at no additional cost to the Department (except for system time). Studies may include manual review, analysis, and computations related to subjects such as:

   a) Procedures billed/paid;

   b) Clinical Screenings scheduled/conducted;

   c) Claims Inquiry Form (CIF) processing;

   d) Resubmission Turnaround Document (RTD) processing;

   e) Treatment Authorization Request (TAR) processing;

   f) Front-end document entry; and

   g) Provider/beneficiary demographic utilization.

   Report the findings for the requested study within thirty (30) calendar days of the Department's request. The Department shall make no more than twenty-four (24) such requests per State fiscal year. System computer time necessary to generate data for the research necessary for these studies shall be paid on an hourly reimbursement basis (see Exhibit B I, Hourly Reimbursements section);

10) Reflect appropriately and accurately all claims, NOAs, TARs, adjustments to claims/NOAs, TAR extensions/re-evaluations, adjudicated CIFs, and retroactive rate adjustments, in all reports for the reporting period during which processing occurred unless otherwise specified by the Contracting Officer;

11) Verbally notify the Contracting Officer within twenty-four (24) hours of detection or anticipation of any discrepancy of report information (e.g., invalid provider identifications, dates, and dollar amounts) or other problems affecting the production, availability, and or distribution of CD-MMIS

reports. The Contractor shall follow up the verbal notification in writing via a Problem Statement within two (2) State workdays of the initial problem identification. If the Contractor determines that the Department's input or direction is required to resolve the problem(s) the Contractor shall also provide an explanation describing the desired input along with any applicable timetables and projected corrections as set forth in the Problem Correction System Procedures section;

12) Modify report delivery locations, number of report copies generated, report medium and/or delivery frequency by report user at no additional cost to the State. Modify report medium from hardcopy to electronic media (e.g., magnetic tape, diskette, CD, Internet, or microfiche) at no additional cost to the State as specified in the CD-MMIS documentation. Changes shall be made upon the request of the Contracting Officer according to the following schedule as per individual report specification:

REPORT PRODUCTION DATES	DATE CHANGE REQUIRED
Monthly, bimonthly, quarterly, semi-annually, annually	Next report production cycle
Daily, weekly, on-demand, On-request, on-line, special reports	Within thirty (30) calendar days of the request

13) Provide an ad hoc report (i.e., special unspecified reports) capability to provide claim payment history and statistical information or data within twenty (20) calendar days of the Department's request. With the Contracting Officer's approval this period may be extended. There are no limits on the number of ad hoc report requests. The Department's requests for ad hoc reports may or may not be compatible or suited to report writer packages. Once an ad hoc report is developed, the Contractor may be required to do subsequent runs, including running the report again with different input data. The Contractor shall save report parameters to facilitate reruns. Initial development of the ad hoc report shall be done by the Systems Group staff with Department staff input. Ad-hoc reports must be verified, by the Quality Management staff to ensure reporting data is correct. System computer central processing unit (CPU) time necessary to generate ad hoc reports including the subsequent runs shall be paid on an hourly reimbursement basis (see Exhibit B I, Hourly Reimbursement section).

13.3 REPORT PRODUCTION

The Contractor shall:

1) Ensure that all report headings, excluding data files, have a standard format. The heading shall include:

   a) Program name,

   b) Report name and number;

   c) Date and time the report was produced,

   d) Date of the report (reporting period covered by the report), and

   e) Page number (numeric).

   The above listed elements shall be in the same position on all CD-MMIS reports;

2) Ensure that all reports produced on microfilm and/or microfiche are legible and meet the standards outlined in the Data Processing and Documentation Responsibilities section;

3) Produce reports that are legible and print each report with either six (6) or eight (8) lines to the inch;

4) Submit any modifications to change the paper stock used for hardcopy report production to the Department for approval of paper size, color, and weight prior to making the change;

5) Produce reports that provide record counts and processing control totals for balancing and control of each subsystem function and/or module;

6) Verify that the correct and updated files are used in the production of all reports;

7) Ensure accurate report production by verifying that:

   a) Reports reflect CD-MMIS Detail Design Specifications and Documentation;

   b) Reports balance within themselves;

   c) Reports reconcile with other reports with similar data;

   d) Claim, TAR, NOA, CIF, MC177-Share-of-Cost facsimile, and provider data are edited pursuant to the

Medi-Cal dental policy to ensure valid data is passed to the reporting programs;

e) Data passed to the reporting programs reflect the data descriptions in the Data Element Dictionary (DED) or the report element definitions; and

f) Reports reflect data from the most recently completed claims processing cycle. Reports that reflect final adjudicated documents data, shall annotate if the report uses date-of-service or date-of-payment information.

8) Produce and deliver to the Department a biweekly listing of all reports produced during the previous two (2) weeks. This listing shall include:

a) Report name and number;

b) Production date and time;

c) Date of report (reporting period covered by the report);

d) Type of media;

e) Number of copies of each report produced; and

f) Delivery location of each report.

9) Maintain uniformity and comparability of data and files maintained throughout CD-MMIS;

10) Generate corrected copies of any report, including Claims Detail Reports (CDRs) and Aged History Reports (AHRs), within five (5) days of the date the Department or the Contractor determines the report to be inaccurate or deficient. Corrected copies shall be generated for any reports containing report deficiencies that are identified by the Department within six (6) months after the report production date. Ensure that all corrected reports (re-runs) are so noted on page one of each report;

11) Produce and deliver, as directed by the Contracting Officer, at no additional cost to the Department, additional copies of any report. Additional copies of each report (excluding AHRs and S/URS CDRs) will not exceed ten (10) beyond the current report production as defined in the Report Distribution List and Detail Design Specification and Documentation (excluding AHRs and S/URS CDRs). Additional copies of S/URS CDRs and AHRs shall not exceed one (1) report copy per request; and

12) Produce all reports on compact disk to allow data to be accessed by a personal computer.

13.3.1 REPORT DELIVERY

The Contractor shall:

1) Deliver reports to report users on a timely basis. Timeliness of reports is essential to CD-MMIS operation. Delivery shall be made on State Workdays as outlined in the Report Distribution List unless otherwise required by the Contracting Officer. Timely report delivery is measured by receipt date of the report by the identified report user, and the delivery times as defined in the following schedule:

   a) Daily Reports - deliver by 12:00 p.m. PST on the first (1st) State workday following the report date;

   b) Weekly Reports - deliver by 12:00 p.m. PST on the first (1st) State workday of the week following the reporting week;

   c) Monthly and Bimonthly Reports - deliver by the fifth (5th) State workday of the month following the end of the reporting month. The exception is that the monthly reports produced from the TAR system shall be delivered by the first (1st) State workday immediately following the report month;

   d) Quarterly Reports - deliver by the fifth (5th) State workday of the month following the report quarter;

   e) Semi-Annual/Annual Report - deliver by the twelfth (12th) State workday of the month following the reporting period;

   f) On-Demand/On-Request Reports - deliver by 10:00 a.m. PST the next State workday following the request;

   g) On-line Reports - data shall be available by 10:00 a.m. PST the day following the report date. See On-line Availability and Response Times section; and

   h) Special Reports - deliver within ten (10) State workdays of the Department's request, unless otherwise directed by the Contracting Officer.

2) Deliver reports utilizing the Contractor's courier service, U.S. Mail, or parcel service. Delivery to locations within twenty-

five (25) miles of the State Capitol Building shall be by courier service, and delivery outside of this radius shall be via U.S. Mail or parcel service;

3) Ensure that delivery receipts are prepared for reports delivered to each report user located within twenty-five (25) miles of the State Capitol Building. The delivery receipt shall include:

   a) Current Date;

   b) Report Frequency;

   c) Report User;

   d) Delivery location;

   e) Report number and name;

   f) Report medium;

   g) Report date (reporting period); and

   h) Space for report user signature and date.

4) Mail reports with a destination outside the twenty-five (25) mile radius to comply with the delivery requirements noted in item (a) above; and

5) Provide reports on the following media as defined in the Reports Distribution List or as specified by the Contracting Officer:

   a) Magnetic tapes and tape cartridges - Contractor tapes must be compatible with Department computer hardware and software;

   b) Hardcopy reports - Collate and burst all reports as required by the Contracting Officer;

   c) On-line reports - Ensure all on-line reports are available and accessible as described in the Data Processing and Documentation Responsibilities section;

   d) Diskettes, for use on PCs, three and one-half inches (3-1/2”) and compact disk in a density specified by the Department, and produced on request; and

   e) Direct electronic transmission.

13.3.2 CYCLE TIME REPORTS

The Contractor shall produce general cycle time reports based on the requirements specified in Exhibit A, Attachment II, Operations section.

13.3.3 BILLING REPORTS

The Contractor shall produce General CD-MMIS Billing Reports as specified in Exhibit A, Attachment II, Operations section.

13.3.4 THIRD PARTY LIABILITY REPORTS

The Contractor shall generate monthly reports for the Department displaying claim counts and dollar amounts for all claims cost avoided. This report shall designate counts and dollar amounts due to other health insurance and Medicare Part A, and Part B. These reports shall separately identify the number of claims and amount cost avoided or recovered in those cases where the Contractor, or its parent entity, is the liable third (3rd) party. Should the Contractor identify dental coverage previously unknown to the Department, the Contractor shall report this information to the Contracting Officer within ten (10) calendar days of discovery, in an automated format to be prescribed by the Contracting Officer.

13.4 DEPARTMENT RESPONSIBILITIES

The Department is responsible for the following functions:

1) The collection of relevant data from a number of diverse input sources such as, but not limited to:

   a) Medi-Cal Paid Claims Tape (MARS Subsystem) from the Contractor;

   b) Child Health and Disability Prevention Program (CHDP) tape from the Contractor;

   c) Other dental coverage information from Health Insurance
   Questionnaires (DHS 6155);

   d) State-maintained eligibility data;

   e) State financial planning and reporting system data;

f) Other reports from the Contractor, i.e., accounting reports, special reports, budget information, etc.; and

g) Other claims processing activities of the Department, the Department's fiscal intermediary for medical claims processing.

2) Monitoring of the data needs of Medi-Cal Dental Program management by functional area;

3) Responding to inquiries from the Governor, the Legislature, and various other public and private agencies. This function includes initiation of special research projects and special one-time computer programs;

4) Monitoring of the Contractor's production of timely and accurate reports;

5) Performing periodic audits of all reports generated by the Contractor (both internal reports and those generated for Department use);

6) Providing information to the Contractor regarding reporting requirements as follows:

a) Medi-Cal Dental Program changes that might affect Contractor reporting. The Contractor shall be responsible for analyzing changes to determine which, if any, reports are impacted by the change, and identifying those changes to the Department;

b) Policy directions related to the reporting function;

c) Report changes, (e.g., format, data elements) required by the Department. This shall not preclude the Contractor from making suggestions that could enhance reporting;

d) All eligibility data required for Contractor reporting on eligibility;

e) Coordinate transmission of program data to the Contractor (e.g., eligibility data) and coordination of data received from the Contractor (e.g., paid claims tapes, budget and accounting reports);

f) Providing Department liaison services in the following areas to coordinate reporting with Contractor: data processing, statistical and research reporting, report production and delivery, research/problem solving activities, and report accuracy and data validity;

g) Coordinating reporting responsibilities in those areas where the Department and Contractor share such responsibilities; and

h) Notifying the Contractor of any changes (additions or deletions) to the Report Distribution List.

7) Submit Buy-in data to the Contractor to assist in the production of the Medicare Participation Analysis Report.

14.0 DATA PROCESSING AND DOCUMENTATION RESPONSIBILITIES

14.1 OVERVIEW

This section describes the CD-MMIS data processing and documentation standards and/or requirements to which the Contractor must adhere. The standards and requirements have been set forth throughout this section when producing, developing, and maintaining CD-MMIS manuals for newly created systems and/or processes.

14.2 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) Provide its standards and current practices for all areas and requirements cited in this section to the Department for approval;

2) Develop programs using structured design and programming techniques. The design and programming techniques shall be an industry-known structured package or a combination of industry-known packages, such as Yourdon and Warnier-Orr;

3) Prepare a written request for approval by the Department, and obtain approval, before implementation and documentation acceptance, of any alteration to a requirement or produce other forms of documentation;

4) Include the following in all documentation when created or updated by the Contractor:

   a) The current State of California and Department of Health Services' insignias and other related State of California identification. The Contractor's insignia or name of the Company is not acceptable on the documentation;

   b) A cover page showing all changed/added/deleted pages for each revised documentation item; and

   c) A control number cited on each page.

5) Establish and use a convention to track revisions that shall be identified on all documentation items and programs submitted to the Department. This convention shall provide

an audit trail to indicate the revisions, the system and/or process change (e.g., SDN, enhancement, DOIL) that necessitated the revisions, and shall consist of the following:

a) Control number - relates to an audit number, change control number, or a Department-approved number;

b) Implementation date - date of the implementation; and

c) Revision indicator - used to identify the revision on each page of the documentation. ChangeMan level numbers shall be used in CD-MMIS program code.

6) Update and distribute all revised documentation, including final program design documentation, covered by this section no later than thirty (30) days after implementation of system development notices (SDNs); and

7) Update and distribute all revised procedure manuals to the Department no later than 30 days after any changes to processes or programs occur.

14.2.1 CD-MMIS NAMING CONVENTION

The Contractor shall:

1) Adhere to the naming convention that has been established for the CD-MMIS. This naming convention was established to easily identify subsystems, files, reports, and programs. All documentation naming conventions must be consistent from general design to the detail design documentation. Any additions or exceptions to the CD-MMIS naming conventions must be approved by the Department prior to being implemented.

2) The structure of the module (program) naming convention is DULNNNMT, where:

a) D = Constant identifier for Medi-Cal Dental Program

b) U = Sub-System

i. A = State ad hoc reporting

ii. C = Claims adjudication and payment

iii. E = Eligibility

iv. F = Reference

v. M =MARS

vi. P = Provider

vii. R = Recipient

viii. S = S/URS

ix. U = Utility

c) L = Different functions depending on the member type

For Source Code members, the value of L specifies the language type:

i. A = ALC

ii. B = COBOL

iii. C = CULPRIT

iv. D = DMS

v. E = Easytrieve

vi. F = FAVOR

vii. I = IBM utilities

viii. M = Data Macs/Track Macs

ix. R = FDR

x. S = Syncsort

xi. T = TMS

xii. U = Docutext

xiii. M = MarkIV

xiv. X = Text Data

For JCL members, the value of L specifies the job frequency:

i. A = Bi-weekly

ii. B = Bi-monthly

iii. D = Daily

iv. I = On-line

v. M = Monthly

vi. = One Shot

vii. Q = Quarterly

viii. R = On Request

ix. S = Bi-annually

x. W = Weekly

xi. Y = Yearly

For Procs, the value of L specifies the procedure type:

i. C = Catalogued procedures

ii. I = Instream procedures

For ADSO entities, the value of L specifies the entity type:

i. D = ADSO Dialog

ii. F = ADSA Function

iii. M = ADSO Map

iv. W = ADSO Record

v. I = ADSO Include process

vi. P = ADSO Premap process

vii. R = ADSO Response process

For IDMS Definitions, the value of L specifies IDMS Definition Type:

i. S = Subschema

ii. U = Subschema definition

iii. D = DMCL module

d) NNN = Sequence number

A series of numeric or alphabetic characters that identifies the program within the subsystem.

e) MT = Different functions depending on the member type.

For source code members, the value of M specifies batch or on-line; the value of T specifies mainline or called program:

i. B = Batch

ii. O = On-line

iii. S = Mainline program

iv. C = Called program

For JCL members, the value of M specifies the environment; the value of T specifies the member type:

i. T = Unit test

ii. S = Systems test

iii. P = Production

iv. J = Job

v. P = Proc

vi. C = Control

For ADSO entities, the value of M specifies the function performed:

i. A = Add

ii. C = Change

iii. D = Delete

iv. I = Inquiry

v. X = Global

14.2.2 DEVELOPMENT AND PROGRAMMING

All database software shall be Integrated Database Management System (IDMS). All application programs must be written in ANSI-COBOL (version OS390 or later) using the structured design and structured programming techniques as stated in the Contractor's standards. All programs must reside on the mainframe, unless prior to written approval is granted by the Contracting Officer. Data base access routines or telecommunication routines may be exempted from this standard with Department approval. All other exceptions must be approved by the Department prior to design and implementation. S/URS-generated COBOL programs are exempt from these standards.

The Contractor shall:

1) Ensure the following standards are adhered to when developing and programming system changes to CD-MMIS. These development and programming standards include CD-MMIS Mainframe Program Code/Application Programs;

2) Ensure that all CD-MMIS Mainframe Program Code and Applications Programs shall:

   a) Be written in COBOL (COBOL for OS/390) and/or "C programming language, as directed by the Department, using the structured design and programming techniques as stated in the Contractor's standards;

   b) Reside on the contractor's mainframe unless the Contracting Officer grants prior approval;

   c) Be upgraded to meet these standards whenever the Contractor makes any changes to any existing CD-MMIS programs;

   d) Be written and maintained with a program's comments section. The program comments shall be located in the beginning of each program and shall:

      i. List the subsystem module that the program is in;

      ii. Describe the functions performed;

      iii. List all called programs (including on-line programs);

      iv. Describe the program PARM or control card;

      v. List all inputs/outputs (including screens);

      vi. Describe the tables and switches;

vii. Describe expected termination conditions and causes; and

viii. Contain a change log

3) Change Log/Data Dictionary

The Contractor shall:

a) Indicate the dates and reason for the change. (e.g., SDN number, problem statement number and emergency fixes). The log shall reflect all ChangeMan level number changes or the Data Dictionary shall indicate the change in the database. The name of the programmer who wrote the change shall be noted. The ChangeMan compile date/time stamp option shall be used; and

b) Maintain all prior change log revisions for each CD-MMIS program that were made by the previous Contractor. This is to ensure a complete historical record of all programming changes.

4) Include Members

a) All CD-MMIS application programs shall use ++INCLUDE members to reflect all file structures used in the program. Working-Storage section file/record structures shall also use ++INCLUDE members. Use of copy statements is restricted to vendor copy member libraries e.g., IDMS BINDS/RECORDS, CICSHAID, etc.; and

b) All CD-MMIS ++INCLUDE members shall have a number referencing the system design documentation, the last maintenance date, and a brief description of the member coded within the actual member itself. A composite listing by subsystem shall be maintained showing all ++INCLUDE members and the CD-MMIS program name(s), which use the member.

5) Program Paragraph Structure

a) A paragraph naming structure shall be identified in the Contractor's standards and shall be followed. Each paragraph shall be less than sixty-five (65) lines of code and each line of code shall include only one (1) COBOL verb; and

b) Application programs shall have at least one (1) comment sentence that describes the function

performed by the paragraph. Each paragraph shall perform only one (1) function.

6) ANSI-COBOL

The Contractor shall not use the following COBOL statements or programming techniques:

a) ALTER statements

b) CORRESPONDING statements

c) NOTE statements

d) DISPLAY/EXHIBIT statements for report data sets

e) COPY statement

f) A GO TO referring to a procedure-name outside the range of a current perform structure.

7) All CD-MMIS report producing programs shall produce a standard report heading. These elements shall be in the same position on all CD-MMIS reports. The heading shall include:

a) Program name

b) Report name and number

c) Date and time the report was produced

d) Date of the report (reporting period)

e) Page number (numeric).

8) Fourth (4^{th}) Generation Programming/Knowledge-Based System (AI) Languages.

a) Upon prior approval by the Department, the Contractor may use Fourth (4^{th}) Generation Programming/Knowledge-Based System (AI) languages (e.g., Natural, SQL, SAS, Focus, and IDMSR) in developing new application programs to improve any process or program related to CD-MMIS. In deciding whether to grant approval, the Department will evaluate the compatibility and integration of this technology with any COBOL application program and equipment hardware existing in the current CD-MMIS operating environment. Consideration will also be

given to ease and cost of program maintenance by a subsequent fiscal intermediary contractor. The Contracting Officer must expressly approve all languages used for CD-MMIS programs other than COBOL; and

b) The Contractor shall be required to use the structured design and programming techniques as stated in the Contractor's standards and shall meet all other data processing and documentation requirements as stated in this subsection.

14.2.3 CD-MMIS JOB CONTROL LANGUAGE (JCL)

The Contractor shall:

1) JCL Coding Requirements

a) Provide a brief narrative for all production CD-MMIS JCL (JOBS and/or PROC) that:

i. Describes the major function(s) performed;

ii. Lists the programs used in the job;

iii. Describes job/step restarts/reruns; and

iv. Describes the program PARMS or control cards.

b) Ensure that the narratives for each query-type language job and/or step describe(s) the function(s) performed and shall contain a reference to the detail design specifications/documentation;

c) Ensure that all CD-MMIS JCL have a Job Change Log that shall be maintained in the same manner as the change log in the Program Code standard. The log entries shall be maintained for the most recent six (6) month period;

d) Ensure that all CD-MMIS JCL utilizes PROC. The procedure PROC overrides shall be described with all possible options listed.

2) JCL Coding Constraints

a) Establish special JOB statement coding structure to indicate a job rerun/restart. The IBM, or equivalent, System Management Facility (SMF), shall collect the data;

b) Ensure that only one production JOBLIB statement is permitted and that no concatenation of this statement is used. Emergency (i.e., EFIX) override statements will be allowed but must be reported in the computer trouble reporting procedures established in the Computer Operations Manual;

c) The use of STEPLIBS is not allowed;

d) Arrange DD (data definition) statements by input, work, then output. Normal system DD statements are coded at the end of each program/JOB/STEP;

e) Reference DD statement names in the detail program flowcharts for each program/job/step; and

f) Include a comment line with all DD statements that references the detail design specifications/documentation. This shall include but not be limited to a brief file name description (e.g., Month-to-Date Adjudication Claims File).

14.2.4 GENERAL SYSTEM DESIGN (GSD)

The Contractor shall develop a GSD that provides a pictorial diagram depicting the overall CD-MMIS flow, each subsystem, and every subsystem module defined. Each diagram shall have a narrative that describes the tasks that are to be performed and the related inputs and outputs shown. The documentation shall be prepared in a format that facilitates updating.

1) The GSD shall:

a) Identify all subsystems and related processes;

b) Identify general flow of subsystems and related processes and include a flow diagram; the flow must identify all major processes;

c) Include sample form layouts, screen layouts, and specifics of all inputs for each subsystem;

d) Include sample layouts for all outputs, including screen layouts and print report layouts, and identify output frequencies;

e) Provide a definition of all edit and audit criteria for all subsystems;

f) Include file descriptions for all files for each subsystem and define data elements; and

g) Include a draft data element dictionary.

2) All programs shown in the GSDs must be defined in the following Detailed Program Design Section.

14.2.5 DETAILED PROGRAM DESIGN

The Contractor shall ensure a detailed program design (DDS)for all CD-MMIS programs. The DDS depicts a pictorial diagram showing all input, work, and output files, and includes a brief narrative describing the major functions performed. A detailed program design shall exist for every program referenced in the general system flowcharts.

1) The Detailed Design Specifications shall:

a) Include a draft of system documentation and must meet all documentation standards described for systems documentation;

b) Include a detailed data element dictionary;

c) Include a data modeling diagram for relational databases or object-oriented programs (e.g., Web site development);

d) Include entity diagrams;

e) Include final copies of the provider manuals and training manuals;

f) Include detailed program logic descriptions and edit logic;

g) Include a list of ++INCLUDES used;

h) Indicate called programs;

i) Follow standard naming conventions;

j) Use ANSI symbols to indicate medium of files; and

k) Indicate the DD statement(s) names.

2) Systems Test Documentation

The Contractor shall ensure systems test documentation exists for each CD-MMIS program, including a detailed system test plan for each systems change (e.g., SDN, enhancement, DOIL) to be implemented into CD-MMIS. The detailed system test plan shall include:

a) Detailed expected outcomes for all test transactions;

b) A copy of all test data, including description;

c) All test results, including screen prints and reports;

d) Retest documents and description of corrective action measures taken; and

e) Contractor's certification that the system is complete and thoroughly tested and ready for user acceptance testing.

14.2.6 DETAILED PROGRAM SPECIFICATIONS

The Contractor shall ensure each major program paragraph is discussed in the Detailed Program Specifications to provide a detailed description of each program in CD-MMIS. The Detailed Program Specification standard shall include the following for each program in CD-MMIS:

1) Program name;

2) Detailed narrative (or facsimile) which describes the logic of the program in addition to the list of inputs/outputs, and the description of the logic used in calling a sub-program;

3) Planned program terminations and related causes;

4) Brief description of the screens and reports produced by the program, if applicable; and

5) Description of the on-line file processing, if applicable.

14.2.7 SCREEN DESCRIPTIONS DOCUMENTATION

The Screen Descriptions Documentation shall provide a complete profile of all the screens used in CD-MMIS. The Contractor shall include documentation that consists of:

1) The screen definition that includes a brief statement of purpose, a screen number (related to the detail design

documentation/specifications), the screen name, and the program (or on-line transaction) that uses the screen;

2) The screen content, that lists all data elements used, and describes data calculations performed, defaults used, and related error messages;

3) An actual copy of the screen showing all data items; and

4) Complete listings of all screens by subsystem, showing screen number, screen name, and producing program or transaction.

14.2.8 LICENSED SOFTWARE

This section describes the standard for the licensed software to be provided and utilized by the Contractor in performing the operational requirements of this contact. The Licensed Software standard applies to the following Department required commercially available software products. Use of commercially available, equivalent products may be used only with prior Departmental approval. In providing approval, primary consideration must be given to the ease and expense of running such packages by a successor Contractor. The Contractor shall maintain a list, approved by the Department, of all licensed software acquired for use in CD-MMIS and all non-mainframe subsystems related to CD-MMIS. The list shall specify software name, type, and version number. The Contractor shall provide the Department with all changes, modifications or customized features it makes to any licensed software referenced in this section and subsections or approved by the Department to be used in CD-MMIS.

1) Mainframe Licensed Software

The Contractor shall maintain all required mainframe licensed software products. The following is a sample list of software only. An all-inclusive list may be found in the CD-MMIS library:

a) CICS/TS (Customer Information Control System/Transaction Server) – Version Transaction Server 1.3/ CICS 5.3 or higher (Teleprocessing Monitor).

A general-purpose database/data communication (DB/DC) interface between the operating system and application programs that manages tasks and terminals;

b) NCP (Network Control Program) (Version 7.8 or higher) – IBM.

NCP is a telecommunication control program for the communications control unit (network);

c) OS/390 Release 2 – IBM – (Version 2 or higher).

OS/390 monitors and controls system throughput with its two primary components, JES2 and BCP (Base Control Program). It controls all job input and output and the scheduling of time sharing users, batch jobs, and devices;

d) COBOL for OS/390 – IBM – (Version 2.2. or higher).

A programming language, which conforms to the American National Standard COBOL 1985;

e) High Level Assembler - IBM – (Version 1.4. or higher).

Translates programs written in assembler language into object code. Provides support for 31-bit mode as well as maintaining 24-bit compatibility;

f) QA Hiperstation – Online Software International, Inc. – (Version 6.2.0 or higher).

QA Hiperstation is an online, menu driven system that automates CICS applications and system testing tasks. QA Hiperstation lets the user observe and/or resolve any differences that arise during testing of new and modified applications. It includes interactive capabilities that allow the user to respond to any testing discrepancies. It runs large volume stress tests in batch mode and reviews the results at a later date;

g) SyncSort – Whitlow Computer Systems – (Version 3.7C or higher).

SyncSort is a data-sorting utility that adapts itself automatically to particular sorting requirements as determined by the computer resources available and by the properties of the input files. SyncSort may be executed in any OS environment;

h) ChangeMan ZMF – Serena Software, Inc. – (Version 4.1.6 or higher).

ChangeMan is used for "version control" of mainframe software components (e.g. source code, load modules, cataloged procedures, job control language, batch control cards, job documentation);

i) RACF (Resource Access Control Facility) – IBM – (Version 2.109 or higher).

A software security system providing control over logical (non-physical) access to computer programs and use of identified data sets by usage of logon identification, user identification, passwords;

j) FAVER – (Data and Tape Management Software) – Goal System International, Inc. – (Version 4.2.4 or higher).

Fast Virtual Export Restore (FAVER) is a utility program for VSAM users featuring high performance data integrity;

k) DFSMS (Data Facilities Storage Management Subsystem) – IBM – (Version 2.10 or higher).

Data Facilities Storage Management Subsystem (DFSMS) is an automated storage management system designed to assist the storage administrator in controlling and using DASD space. Extensive reporting capabilities are available plus functions to free up space, provide backup and recovery, enforce installation standards, and perform device conversions;

l) DFRMM (Removal Media Manager) – IBM – (Version 2.10 or higher).

RMM is a Tape Management System designed to provide the control, reporting capabilities, and facilities to efficiently manage Data Center tape resources while providing absolute tape data set protection;

m) CA-IDMS-DB/DC (Database Management System) – Computer Associates – (Version 15.0 or higher).

A high-performance data base management system that centralizes and controls the data resource;

n) Integrated Data Dictionary (IDD) – Computer Associates – (Version 15.0 or higher).

Stores and maintains information regarding data, whether data is part of a database, conventional file,

teleprocessing network, or manual system, in an organized central repository called the Data Dictionary;

o) ADS/ONLINE – Computer Associates – (Version 15.0 or higher).

The Application Development System/Online (ADS/Online) is a comprehensive fourth (4^{th}) generation application development system that facilitates the creation of online applications;

p) TSOE/ISPF Interactive Systems Productivity Facility (Development Support) – IBM – (Version 5.0 or higher).

A program development tool designed to take advantage of the characteristics of IBM 3270 display terminals and to increase programmer productivity in the MVS environment;

q) WSF2/EOS Report Management System (Operations Support) – Roger Software Development – (Version 1.2or higher).

The Report Management System is designed to control and manage all the reports under its control. It is a menu-driven system that automatically scans the output for system exceptions. It contains an audit trail telling how and when the reports were created, the size, number of pages, who received copies, etc.;

r) Operations and Planning Control (OPC)/ESA – IBM – (Version 2.3 or higher).

(OPC) is a batch scheduling system capable of automatically submitting JCL based on date, time and many other criteria. The product interfaces with ISPF through a series of menus which make adding new work to OPC relatively easy;

s) SDSF (System Display and Search Facility) – IBM – (Version 2.10 or higher).

SDSF is a full screen output processor that extends the capabilities of the ISPF Browse function to sysout data sets residing on JES spool volumes;

t) $AVRS – Software Engineering – (Version 5.0A.22 or higher).

$AVRS is a sysout accumulation, storage, and retrieval system. It is designed to accumulate production batch sysout and optional system syslog. This accumulated data is written to a VSAM database for storage;

u) SAS (Statistical Analysis Software)) – SAS Institute – (Version 8.1 or higher).

SAS is a statistical data collection and reporting language;

v) CMF (Comprehensive Management Facility) – Boole and Babbage, Inc. – (Version 5.4.0 or higher).

CMF is a system monitor designed to measure and report Multiple Virtual Storage (MVS) system performance;

w) Main View Manager – Boole and Babbage, Inc. – (Version 2.6.0 or higher).

Main View Manager is a real time software tool designed to detect, diagnose and resolve problems as they occur;

x) MainView for CICS 5.2.0 – Boole and Babbage, Inc. – (Version 5.3.01 or higher);

y) The Monitor provides monitoring capabilities for CICS;

z) NetView – IBM – (Version 1.3.0 or higher).

NetView is a status monitor that provides a simple way of controlling and monitoring a network. NetView monitors the network and provides automatic reactivation of nodes;

aa) NPN – IBM – (Version 2.5.0or higher).

NPM is a VTAM application that gathers host and network performance data and provides both online displays and offline reports containing this data;

bb) CIMS – CIMS Lab, Inc. – (Version 11.2 or higher;

cc) System utilization, monitoring, and reporting;

dd) GENTRAN - EDI (Electronic Data Interchange) – Sterling Software – (Version 6.0 or higher).

GENTRAN translates data between the CD-MMIS and the ANSI X12 format required of EDI communications;

ee) Connect Direct for MVS – Sterling Software – (Version 4.1.6 or higher).

Direct Connect is an online data communications system that runs in a host mainframe and enables data communications between the host and remote terminals or computers.

14.2.9 SOFTWARE AUTOMATION TOOLS

The Contractor may use various software automation tools that run on an IBM mainframe system and/or distributed microcomputer environment. These automation tools can include program code analyzers and metric tools, data and logic restructuring tools, reverse engineering techniques, and compression software designed to improve existing systems and the maintenance process. The use of any software automation tools shall be subject to prior Department approval.

14.2.10 COMPUTER GENERATED IMAGES ON MICROFICHE AND CLAIM FACSIMILES ON MICROFILM

All microfiche and microfilm shall be produced as outlined by the National Micrographics Association standards for the industry, standards (i.e., MS1 1971 and MS2 1971). The standards apply to computer generated micrographic images. All reports shall be produced on microfiche as required by the Department. All claim, TAR, RTD, NOA, CIFS, and attachments to such documents an/or document facsimiles shall be produced on microfilm.

The Contractor shall:

1) Ensure that the original silver halide film is of archival quality as described by ANSI-PH 1.25 and ANSI-PH 1.28 or ANSI-PH 1.41. The film shall be stored in accordance with ANSI-PH 1.43. Storage procedures shall be detailed in the Backup/Recovery section of the Security and Confidentiality Plan. Silver halide microfilm/microfiche may not be stored with diazo or other types of microfilm/microfiche. The ANSI-PH 4.8 standard for residual hypo shall be met. Independent laboratory tests shall be conducted at least quarterly and the results of these tests shall be delivered to the Department no later than fifteen (15) state workdays after completion.

2) Ensure that the standard density shall meet the negative density standard (for master silver film) determined by the

Department to be .08 through 1.3. The line density and character density shall have a .06 through .09 maximum density.

3) Ensure that the retention period of microfilm/microfiche shall be consistent with the record retention provisions of the Records Retention Requirements.

4) Ensure that duplicates or copies shall be of appropriate density that is clearly readable. Clearly readable shall be defined as to be acceptable as evidence in a court of law. (Evidence Code §1500 et. seq.) First (1st)-generation film shall be maintained for a Department-approved period of time in order to facilitate microfilm/microfiche duplication.

5) Ensure that inspection procedures shall be established to monitor for defects on microfilm/microfiche. Inspections shall be made for:

   a) Images not clear and distinct;

   b) Characters or symbols that are filled in or too light that they are illegible;

   c) Lines which are discontinuous or too light that they are illegible;

   d) Data that is obscured, illegible, or out of focus;

   e) Blisters, tears, or processing stains;

   f) Scratches that appear through image areas;

   g) Finger marks, oil, or grease; and

   h) Improper data alignment to forms overlay.

6) Ensure that quality management procedures guarantee that the report name and number on the top of the microfiche reflect the contents of the microfiche. Also, Department-approved quality management procedures shall be established to assure indexes are complete, accurate, and index numbering is uniform on all microfiche. Microfilm rolls shall be numbered to correspond to the microfilmed source documents.

7) Replace reports that are deficient in any of the above with corrected microfiche no later than fifteen (15) Workdays after notification of the deficiency by the Department.

8) The Department reserves the right to run any test at anytime the Department deems appropriate to assure the above standards are being met.

9) Ensure that the quality of the microfilming of all claims, related attachments, and copies thereof are certified to ensure admissibility as legal evidence in a court of law. Microfilm shall comply with Evidence Code, section 1500 et. seq., and shall meet the requirements of Government Code section 14756 and the standards mentioned in this section.

10) Ensure that the films purchased in any one order shall be limited to a single emulsion batch. The Department recognizes that the Contractor is often unable to purchase film in a single emulsion batch; therefore, the Contractor is required to conduct exposure tests on each batch. These tests determine optimum exposures for each batch used. The test results shall be delivered to the Department no later than fifteen (15) calendar days after the tests are completed.

11) Establish inspection procedures to monitor overlapping of claims, clarity of images, edge warping, illegible characters, blisters, processing stains, scratches, and finger marks. The inspection and quality management procedures shall be at least equal to the National Micrographics Association's standard MS-104 "Inspection and Control of First (1st) Generation Silver Halide Microfilm."

14.2.11 COMPUTER HARDWARE

The Contractor shall:

1) Provide computer equipment that is IBM compatible.

2) Provide supporting studies on an annual basis to verify that the computer equipment is adequate to meet the requirements for CD-MMIS processing, availability, and on-line response time.

3) Obtain approval from the Contracting Officer for the implementation and use of a hardware upgrade or downgrade. The Contractor shall submit the request to the Department and include the projected equipment upgrade or downgrade indicating whether the equipment is an addition, replacement, and/or major modification of computer equipment.

4) Ensure that all personal computers, mini computers, laptops, and peripherals of any type used in this contract are subject to commercially available maintenance/service agreements

that are on the public market or support software that is readily transferable to equipment that is currently on the public market.

14.2.12 CD-MMIS ON-LINE AVAILABILITY, RESPONSE TIMES AND ACCESS

The Contractor's computer equipment, network, operating system environment, and other components shall meet and maintain on-line availability and response time standards established by the Department, and as set forth below.

The Contractor shall:

1) CD-MMIS On-Line Availability

   a) Ensure, notwithstanding the requirements specified in other sections of this contract, that the on-line system availability is defined as the proportion of scheduled time that the central site hardware, systems software, and on-line applications software are available to end terminal users. Availability is expressed as a percentage, defined as the time scheduled less the time down, divided by the time scheduled. On-line system access and availability shall be established for all State workdays between the hours of 7:00 a.m. to 5:30 p.m PST;

   b) Ensure that the Department's system access and availability is not interrupted or superseded, except with the Contracting Officer's prior approval, for any Contractor activity including system maintenance (preventive, scheduled or otherwise) and system or program processing (scheduled or unscheduled);

   c) Provide an electronic pre-notice of any system interruption, shutdown, or file non-access to all on-line users at least twenty-four (24) hours prior to the scheduled system interference; and

   d) Provide verbal notification to the Department on-site management of any system interference or interruption as soon as it is determined if during State workday. The Department shall again be notified as soon as the interference or interruption has been corrected and the system is operating normally. If not during a regular State workday, such notification shall be given to on-site management at the beginning of the next State workday following the determination of the interference or interruption.

2) On-Line Availability Standards

a) Ensure, notwithstanding the requirements specified in other sections of this contract, that each application is available at least ninety-eight percent (98%) of the total time between the hours of 7:00 a.m. and 5:30 p.m. PST on State workdays as determined by a weekly average of five (5) days;

b) Ensure that the maximum CD-MMIS downtime per week does not exceed sixty-three (63) minutes. The total number of CD-MMIS downtimes shall not exceed three (3) times per week with no more than one (1) downtime occurring on any one (1) day; and

c) Perform all system maintenance and file updating activities before or after State Workday hours.

3) System Reports

a) Provide to the Department weekly reports that detail system non-availability for each application. Such reports shall include the:

i. Name of each on-line application;

ii. Number of times the application was down during the week;

iii. Elapsed downtime (start and end times); and

iv. Cause of the downtime.

b) Produce a monthly summary report of the data contained in the weekly reports described in on-line monitoring system below.

4) CD-MMIS On-Line Response Times

a) Meet on-line response time and system processing requirements for the Systems Group and for the various units within the Department requiring on-line access. The measurements for these requirements shall be the same as CD-MMIS processing and CD-MMIS on-line response requirements; and

b) Ensure that the on-line system response times and standards as set forth below are met for all CD-MMIS applications. Standards are used for measuring

internal response time and for measuring terminal response time at each controller.

5) CD-MMIS On-Line Response Time Standards

a) Host site

i. Ensure, notwithstanding the requirements specified in other sections of this RFP, that ninety-five percent (95%) of transactions are processed within three (3) seconds. This shall be measured as the internal response time. To determine if the processed time is being met, the internal response time will be measured;

ii. Ensure that the formula measuring internal response time is: CICS Detach (Termination) Time minus CICS Attach (Start) Time or IDMS Detach (Termination) Time, minus IDMS Attach (Start) Time; and

iii. Utilize the CICS and IDMS Monitoring Package and provide the Department with reports generated by that software package.

b) Terminal

i. Ensure that ninety-five percent (95%) of transactions are processed within three (3) seconds. The three (3) seconds begin from the time the transaction is entered (the "enter" button is pressed) until all data is displayed on the screen; and

ii. Monitor terminal response time with hardware and software provided at the controller located at each Department user location.

6) On-Line Monitoring System

a) Provide an on-line monitoring system to monitor system performance and usage for all Department on-line CD-MMIS users. The on-line monitoring system shall include all necessary equipment, software, procedures, and reports and have the capability to:

i. Measure system performance;

ii. Identify, diagnose, and analyze system problems;

iii. Correct or change system problems; and

iv. Generate monitoring reports identifying location and nature of system problems.

7) CD-MMIS Network Access Telephone Help Desk

a) Provide a CD-MMIS Network Access Telephone Help Desk to assist State on-line CD-MMIS users. The telephone line shall be staffed one hundred percent (100%) of the time between the hours of 7:00 a.m. and 5:30 p.m. PST during each State workday;

b) Maintain a log of all problems reported by telephone. A report of the system problems and their resolution shall be submitted to the Department on a monthly basis. When system problems are identified, the Contractor shall be responsible for contacting all necessary entities, including telecommunications contact persons, to ensure that the problem is followed up and resolved;

c) Process, document, and resolve reactivations, resets of suspended passwords, and other password problems, upon written contact from Department users without intervention of the Contracting Officer. The Contractor shall process requests for password assistance within four (4) working hours of written request from the user.

Obtain Department approval before issuing initial passwords. The Contractor shall be responsible for consulting with the designated Department CD-MMIS Password Coordinator in the event the Contractor is uncertain of the authenticity of the user. The Contractor at no time shall reset a user password over the phone for any reason. All such requests for resets shall be done in writing by the coordinator;

d) The Department reserves the right to approve, amend, or rescind all actions affecting on-line access to CD-MMIS for State users; and

e) Maintain a log to document all contacts resulting in security access changes including resets, reactivations, or menu changes. The log shall be delivered to the Department on a weekly basis.

14.2.13 DEPARTMENT ACCESS TO CD-MMIS

1) Access to CD-MMIS

The Contractor shall:

a) Provide to the Department, complete and immediate on-line access of all CD-MMIS files and use of TSO and SPF facilities utilized by Systems Group staff for the development of computer programs and reports. Department staff shall also be permitted write-access to DASD and tape at the Contractor's data processing center. All utilities and software packages available to the Contractor's Systems Group staff shall be available for use by designated Department staff. If the CD-MMIS files are not in a format to be accessed by the more common utility programs (e.g. SAS) the Contractor shall make appropriately formatted files of data available on request, at no additional cost to the Department. This access would provide the Department the ability to produce reports that would otherwise be produced by the System Group. All costs related to activities by Department staff under this paragraph shall be included under the Contractor's fixed price or hourly reimbursement costs, as appropriate;

b) Ensure that only authorized Department staff have on-line, read-only capability (cannot be updated) access to all CD-MMIS production files. The Contractor shall maintain disk storage space to support test files used by the Department staff. CPU hours used shall be maintained for the purpose of CPU reimbursement. Maintenance of disk storage space is not reimbursable. The Contractor shall provide training and certify designated State staff on the use of the system and any or all of its software. This training is intended to familiarize Department staff with the systems for testing, and report production, etc. This training course shall be conducted by fully qualified staff and shall fully utilize the CD-MMIS Processing User Guide (see below). There shall be a minimum of two (2) classes each year with a limit of fifteen (15) Department staff per class. The first (1st) class shall be given within four (4) months of the Contract's effective date;

c) Ensure that computer jobs submitted by Department staff during normal business hours are assigned one (1) of two (2) priorities: high or low. High priority jobs are jobs submitted with JCL run time parameters of two (2) CPU minutes or less and require no tape mounts. High priority jobs shall be executed within five (5) minutes of the time they are submitted. . Low priority jobs are all other jobs. Low priority jobs shall be

executed within four (4) hours of the time they are submitted;

d) Ensure that the Department has full access to CD-MMIS. In order to assist the Department in its monitoring function, the Contractor shall:

i. Provide access for Department monitoring staff to validate all tests run by the Contractor. The Contractor shall provide any of the test run formats or documentation to Department staff for duplicate monitoring to validate the Contractor's test results;

ii. Provide Department staff with a copy of any CD-MMIS data file, including the CD-MMIS tables file, and deliver within five (5) days. The Contractor shall allow Department staff to order file copies on-line;

iii. Assure that the entire CD-MMIS is available to Department staff for testing. The Department shall have authority to test the CD-MMIS production system to ascertain that changes have been installed correctly and policy is being executed as required;

iv. Provide the means for the Department to generate random samples of claims, TARs, or RTDs at various stages of adjudication, suspense, or adjudicated by claim type, data control center, procedure code, or error code;

v. Provide the means for the Department to measure overall staff and system performance in claims processing, from input preparation through dental review, and from edit suspense through claims adjudication;

vi. Provide the Department with access to Contractor’s working papers used in the production of quality management reports; and

vii. Provide the Department with a copy of documents upon request (media type will be determined by the Department).

e) Ensure that the on-line access enables the Department to monitor the following:

i. Computer usage;

ii. Computer operating environment;

iii. CD-MMIS production ChangeMan libraries;

iv. CD-MMIS production load module libraries;

v. Data security procedures;

vi. Computer's operating system console log data;

vii. Data element dictionary information; and

viii. CD-MMIS data files.

2) HHSDC Data Link

The Contractor shall:

a) Provide a data link between the Health and Human Services' Data Center (HHSDC) and the Contractor's mainframe computer to provide pass-through capability to the Department for access to all CD-MMIS files, and for electronic transmission of data between them. The Department will control access to the pass-through facility. Once authorized access has been granted, the Contractor shall be responsible for security for all authorized users;

b) Ensure State CD-MMIS users are able to pass-through to HHSDC for use of its system; and

c) Establish the means to communicate through electronic mail with the Department's staff and the Contractor's key personnel, Quality Management, Systems Group, Provider Services, and S/URS staff.

3) Processing User Guide

The Contractor shall:

a) Develop, maintain, and update an Automated Methods and Procedures Plan (currently titled State On-line Access Procedures Manual). The purpose of this plan is to define access to the mainframe and non-mainframe applications of the system for Department users. The plan shall provide the following information:

i. Lists and explanations of the file conventions used within CD-MMIS (both tape and disk);

ii. List and explanations of CD-MMIS software;

iii. Examples of JCL for major software products;

iv. List of TSO members containing program examples for each programming language from item three above;

v. List and description of all possible codes used within the JCL (e.g., job classes, output forms);

vi. Methods and programmer tips for executing jobs on the Contractor's mainframe including creating/editing program code, testing programs, reviewing job output, printing of job output, and transmitting and receiving data electronically from/to HHSDC;

vii. Use of written programmer utilities used by the Systems Group; and

viii. Methods for researching on-line data sets, especially programs, data files, and tables.

14.2.14 COMPUTER OPERATIONS PROCEDURES

The Contractor shall:

1) Develop procedures and/or systems that ensure the most efficient manner for running, controlling, and balancing all CD-MMIS mainframe and non-mainframe jobs or tasks.

2) Use an automated job scheduler.

3) Develop, maintain, and document procedures in the Computer Operations Manual which shall include:

   a) Total Data Entry Procedures and Training Manual, Computer Media Claims (CDC), KDE, and OCR.

      The manual shall describe all data entry instructions, including KDE, and OCR. The procedures shall include, by type of data, the description, the formats used, the programming specifications developed, function of the data, and the data destination;

   b) CD-MMIS Job Steps

      The manual shall describe all computer instructions necessary for performing each step in a CD-MMIS job.

This includes a brief description of each step, related to checkpoint/restart functions, input/output descriptions and possible program terminations with resolutions;

c) CD-MMIS Job Scheduling

The manual will document the instructions necessary for scheduling each CD-MMIS job. This includes a brief description of the job, its run sequence, other related jobs, check-point/restart/rerun specifications, and special job characteristics;

d) Trouble Reporting Procedures and Reports

The manual shall describe the computer trouble reporting procedures and reports developed for CD-MMIS jobs. The procedures shall contain job data by the subsystem, job name, date/time, indicated problem, resolution, programmer, manager involved, and JOBLIB override indicator. This manual shall include requirements and procedures to be followed by programming/technician staff when completing the Trouble Report recording EFIX's, and reporting EFIX's to the Department (e.g. through Problem Statements);

e) Balancing Procedures and Reports

The manual shall describe the procedures and reports developed to balance and verify all CD-MMIS reports and jobs where applicable; and

f) Quality Control of CD-MMIS Production Libraries

The manual will include procedures and reports developed to maintain quality management functions associated with CD-MMIS production libraries (i.e., ChangeMan source libraries, load module library).

4) Ensure these manuals and procedures are updated at all times. Revised documentation shall be submitted to the Department no later than thirty (30) days after any change occurs.

14.2.15 ON-LINE DATA DICTIONARY

The Contractor shall:

1) Ensure that CD-MMIS data elements are available online to Department users. Computer Associates' product Integrated

Data Dictionary (IDD) supports the CD-MMIS database information/Data Dictionary.

2) Provide a data dictionary naming structure that shall be identified and described in the Contractor's standards, (see On-line Data Dictionary in this section).

3) For the application programs that are solely in batch processing environment, define all data elements that are not defined already in the IDD. The Data Dictionary shall describe and maintain the following information for each data element:

   a) Data element name;

   b) Unique data element number;

   c) Description of the data element and all of the possible values indicated and defined;

   d) Cross-reference to the Federal MMIS general design number;

   e) Format of the data element;

   f) Applied security and confidentially requirements;

   g) File cross-reference (a where-used list);

   h) Originating source;

   i) Program listing source code name (COBOL name);

   j) Programs, which use or update the data element;

   k) S/URS Measurement Items (MIs) that use or access the data element and the S/URS MIs data element name, if different;

   l) Edit/audit error codes that relate to this data element; and

   m) Report names and numbers, which use the data element.

4) Make all necessary and appropriate updates to the Data Dictionary and its documentation whenever any changes are made to CD-MMIS programs, e.g., as a result of the generation of new SDNs, Change Orders, reports, or resolution of system problems, etc. Also, the Contractor

shall be responsible for providing to the Department any customized enhancements, additional features, or interfaces (or revisions to such features) that the Contractor develops in conjunction with the proprietary software.

5) Print for the Department or ensure that the Department has the capability to print on demand, a hardcopy version of the Data Dictionary. Also, training in the use of the Data Dictionary shall specify standards and procedures the Contractor uses to maintain the CD-MMIS Data Dictionary.

6) Maintain the Data Dictionary Procedures Manual and Data Dictionary User Guide developed during Takeover (see Exhibit A, Attachment I, Takeover). These documents shall specify standards and procedures the Contractor uses to maintain the CD-MMIS Data Dictionary.

14.2.16 FILE LAYOUT DESCRIPTIONS

The Contractor shall:

1) Provide and maintain a File Layout Manual in which every file in the CD-MMIS shall be defined. The documentation shall include a narrative of the file including the purpose, logical function, and processing intent. A brief narrative of each logical record and a pictorial display of all logical records shall be included. The following items shall also be included as appropriate:

   a) On-line definition and processing intent;

   b) Physical description and retention cycles;

   c) Related ++INCLUDE members;

   d) Programs accessing the file;

   e) Backup requirements;

   f) List of data elements used;

   g) Type of sequences(s) of data;

   h) Frequency of processing;

   i) Average number of records contained;

   j) Applied security and confidentially requirements; (added)

2) Every file identification number must be consistent with the system design documentation.

14.2.17 USER DOCUMENTATION

The Contractor shall:

1) Ensure all CD-MMIS user manuals and procedures are written at a level that would facilitate an inexperienced user's ability to understand them. All user manuals shall also contain a comprehensive subject index. The indices shall be updated no less than once each quarter. The documents shall be easily maintainable;

2) Ensure training manuals are derived from user manuals or procedures described in this subsection, and used for the applicable training given as required under Exhibit A, Attachment II, Operations, Staff Training Requirements Section. The training manuals for each course or class shall be generated from the most current documentation;

3) Submit to the Department for approval within thirty (30) days from implementation of system and/or policy changes, proposed revisions to its user manuals or procedures. Changes shall be distinguished by change indicators. Unless otherwise directed, the Contractor shall not utilize proposed procedural changes prior to Department approval;

4) Ensure each user documentation shall contain a brief description of the task(s) to be accomplished, an overview of the functional flow of data or information through the procedures, a description of the organization using or receiving the procedures and other specifications described in the following sections.

   The following sections describe some of the components of User Documentation. For each component below, the Contractor shall:

   a) Accounts Receivable Policies and Procedures Manual

      Describe all procedures used in the accounts receivable and related financial activities. Documentation of all CD-MMIS financial transactions shall be developed;

   b) Edit/Audit File Control Procedures

      Describe all procedures used in the development and maintenance of the edit/audit file. This document shall

include the actual modification procedures of edit/audit values and/or criteria;

c) Suspense Processing Manuals

Describe all procedures used in the processing of suspended claims for all claim types. These procedures shall be arranged by the edit/audit category of error (e.g., provider, recipient). Each edit/audit error shall indicate the name, description, criteria used, action to be taken, overrides (if any), and related EOB messages(s).

Any processing exceptions utilized by the Contractor or by the Department must be recorded and a full written report made of the exception for each application. Also, any additions to the suspense processing manuals used by the Contractor in processing claims must be delivered to the Department for review and approval;

d) Provider Manuals

Define and describe all procedures used by Medi-Cal Dental providers in the billing and processing of claims. This manual shall be arranged by claim type and include related policies, a keyword index, a brief overview, correspondence location(s) and instructions for out-of-state providers. As revisions are made to the format of this manual, the Contractor shall be responsible for updating the provider manual according to the revised format;

e) Provider Services- Manual

Define and describe all procedures that are used in the billing and processing of claims. This manual shall be arranged by claim type and include policies, a keyword index, a brief overview of the functions performed, and research methods involved;

f) Document Handling

Develop procedures and/or systems that ensure the most efficient manner to control documents. The Contractor shall develop and maintain documentation and procedures in the following areas:

i. Reports - The Reports Distribution List shall be developed and maintained in accordance with the General Reporting Requirements section. The

documentation will be two (2) sequence: one (1) by user (receives the report) and the other by report number; and

ii. Microfilming/scanning of Claim Documents - The Contractor shall develop, maintain, and document the coordinated system that is designed to accomplish the microfilming/scanning tasks.

This documentation shall describe the microfilming/scanning activities and equipment used. The procedures shall include quality assurance functions to ensure that the microfilm/image is admissible as legal evidence in a court of law;

g) Document Retrieval

Develop, maintain, and document all manual and automated procedures used to retrieve documents in CD-MMIS. The document retrieval system documentation shall include:

i. A daily Document Retrieval Request Summary report of each document type that has been requested on-line;

ii. A monthly Document Retrieval Performance Report; and

iii. A quarterly Records/Files Summary of all records and/or files maintained under this contract. The summary shall include, at a minimum, the name of the file, the medium of retention (e.g., on-line, tape, etc.), duration (how long the file is maintained in the defined media), disposition (e.g., subsequent arrangements for retention or purge), and access (the methodology necessary to gain access to the file). This summary shall be sorted by production schedule (e.g. daily, weekly, monthly, quarterly, semi-annually or annually).

h) Performance Reporting

Describe the procedures and policies of the resource management system that shall be used to evaluate the performance, productivity, and accuracy of work performed in the CD-MMIS. The performance reporting shall include all Contractor employees in such areas as claims processing (input preparation, professional review), claims adjudication, data entry, computer operations, programming and cost

reimbursable and hourly reimbursable staff. Also to be included are any and all production incentive plans and a description of how such plans do not compromise quality assurance standards as they relate to claims payment accuracy. The results of these procedures and policies shall be made available to the Department upon request;

i) Organization and Staffing

Describe the organization that supports the operations of CD-MMIS (including subcontractors). The description shall provide:

i. Organization charts and descriptions showing the organization's location of the project in the Contractor's firm, the functional responsibilities of each organizational unit, the delegation of responsibilities to organizational units, organizational decision-making points, and actual unit staffing by classification;

ii. Completed job descriptions (specifications) for all classifications, including job title, functional responsibilities, and experience requirements; and

iii. Monthly personnel acquisition reports for the current and previous twelve (12) months showing the number of staff by functional area and by classification.

j) Audit Procedures/Policies Manual

Describe the audit procedures and policies established to verify that CD-MMIS performs as designed and programmed. The audit data collection and tracking procedures shall be identified and the data security measures shall be defined. The procedures and results of the routine audits performed by the Contractor shall be maintained in this documentation; and

k) Other CD-MMIS Procedure Manuals

Develop, maintain, and update the documentation for all procedure manuals used by the Contractor in performing the operational requirements of this contract. The Contractor shall also develop, maintain and update the documentation for any CD-MMIS procedure manuals developed during Takeover, or as

the result of modifications made during the life of this contract (e.g., SDN, DOIL, Change Order).

14.2.18 HARDWARE AND SOFTWARE CONFIGURATION MANUALS

The Contractor shall:

1) Develop, maintain, and update a Hardware and Software Configuration Manual within thirty (30) days of implementation of hardware and software. The Hardware and Software Configuration Manual shall describe the computer environment that processes CD-MMIS claims, supports data communications, programming support functions, and related CD-MMIS activities.

2) Update the documentation within thirty (30) days of the implementation of any new hardware or software and shall describe the following areas:

   a) Hardware

      This documentation shall include a description of all computers, input/output and storage devices, controllers, and other related equipment that support the CD-MMIS, including all equipment monitoring the on-line system usage and access for CD-MMIS users. The documentation shall describe the acquisition schedule of future equipment. A section of the documentation shall describe the backup facility for the system;

   b) Communication Network

      This documentation shall include a description of all terminals, EDI Claim entry, OCR's, Remote Entry (RJE) sites, related equipment, and micro-image terminals that support CD-MMIS. Sections shall be included to describe the communication backup facility and the system performance monitoring equipment used at the computer host site and at the various terminal locations. An acquisition schedule of future equipment shall also be included;

   c) Operating System Release(s)

      This documentation shall describe the operating system in production. The documentation shall include the on-line monitoring system for CD-MMIS and any operating system enhancement packages. A section

shall address the implementation schedule(s) of related system support updates;

d) Hardware and Software Contracts

This documentation shall describe all computer hardware and software contracts for the equipment and related software packages that support CD-MMIS, including its on-line network monitoring;

e) Programming and Development Environment

This documentation shall describe the programming development computer facilities (including subcontractor facilities) that support CD-MMIS. The documentation shall include the programming development tools available and contractual impacts to this facility, hardware/software-related constraints the Contractor owns, and constraints related to the facility (e.g., lease agreement size, raised floor, air conditioning).

14.2.19 CONTRACTOR DOCUMENTATION RESPONSIBILITIES

The Contractor shall:

1) Prepare and maintain documentation that conforms to the documentation standards that have been submitted and approved by the Department;

2) Develop and maintain programs and JCL that meets (or exceeds) the standard requirements and the Contractor standards;

3) Meet or exceed all other standards stated in this section;

4) Use IBM 3480 tape cartridges as the standard for all data exchanges between the State and the Contractor, unless otherwise specified by the Department;

5) Prepare reports and/or complete checklists to confirm that standards have been followed;

6) Prepare written requests for exceptions to standards;

7) Prepare written requests for revisions of standards and receive approval from the Department prior to implementation;

8) Prepare microfilm of claim and related documents according to CD-MMIS microfilm standards;

9) Prepare microfiche of CD-MMIS reports in accordance with the established microfiche standards. Only the following CD-MMIS reports below shall be microfiche:

   a) CP-O-EOB

   b) CP-O-CHK

   c) CP-O-NOA

   d) CP-O-NOA(R)

   e) CP-O-NOA-P(EDI)

   f) CP-O-RTD-P(EDI)

10) Require and certify that the hardware and its operating environment are IBM compatible;

11) Acquire hardware and software that meets or exceeds CD-MMIS on-line availability and CD-MMIS on-line response time requirements as set forth in this section; and

12) Review all work performed by subcontractor(s) to ensure all CD-MMIS standards are followed and documentation items are maintained, updated, and delivered as scheduled.

14.2.20 CD-MMIS DOCUMENTATION DELIVERABLE REQUIREMENTS

Upon implementation of improvements, enhancements, or changes, the Contractor shall update all required documentation, current versions of the programs, JCL, ++INCLUDE members, and screen members. These updates shall be transmitted to the Department for approval no later than thirty (30) days after the implementation date. The Contractor shall produce the updates upon receipt of Department approval and prior to the next contract month. The Contractor shall correct all non-approved updates no later than three (3) State Workdays after receipt of the notice of non-approval. The number of approved updates to be provided to the Department will be set by the Department, but shall not exceed forty (40) copies. The Contractor shall maintain a distribution list of all deliverables submitted to the Department. The following items are required with any implementation:

1) All applicable documentation updates on system changes, modifications, and/or improvements;

2) Computer representation of all altered programs, JCL, ++INCLUDE members, on-line screens, control card libraries, and all customized enhancements or additional features to otherwise proprietary software that the Contractor develops;

3) Completed checklists of all documentation items that were changed and updated; and

4) Completed checklist of all changes that indicate which standards and/or documentation items were affected.

14.2.20.1 MONTHLY DELIVERABLES

The Contractor shall deliver the source files and documentation and/or checklists described below prior to the fifth (5^{th}) State workday of each contract month:

1) Source Files

   a) Deliver a ChangeMan migrated source file on tape cartridge for all programs and ++INCLUDE members during the prior month into the production library. A directory listing showing all programs on the source file shall be included. This requirement includes all Contractor-developed customized enhancements or additional features to proprietary software used in CD-MMIS that the Contractor has installed during the prior month;

   b) A ChangeMan source file for all production JCL and control card libraries that were changed during the previous month. Including a directory listing showing all JCL on the file;

2) Documentation and/or Checklists

   a) Deliver all prior applicable documentation that reflects changes or updates implemented during the month. These shall include all documentation identified and categorized as follows:

      i. A documentation checklist for each program migrated during the month into the production library. The checklist shall indicate all documentation changed by the Contractor;

      ii. A ChangeMan directory listing showing the entire CD-MMIS program source, ++INCLUDE

members, and JCL production libraries. The listing shall show all production members, level numbers, last accessed, user, and last maintenance date;

iii. All applicable documentation that reflects changes or updates that were implemented during the previous month. These items shall include, but are not limited to, all documentation identified in this section and are categorized as follows:

A. General Subsystem Designs

B. Detailed Program Designs

C. Detailed Program Specifications

D. Report Descriptions and Documentations

E. Screen Descriptions and Documentation

F. Licensed Software

G. Computer Operations Procedures

H. Data Descriptions

I. User Documentation

J. Hardware/Software Configuration

iv. An audit listing showing all programs (including CICS) migrated into the production library (Batch, IDMS, and CICS) during the prior month. This listing shall include a complete library report that contains load module size, revision date, and program name for each CD-MMIS production library;

v. A listing of the CICS environment. This report shall show all CICS transactions and programs (FCT, PCT, & PPT);

vi. A detailed report of all CD-MMIS abnormal terminations (computer operations trouble report) that identifies the problem program resolution(s);

vii. A PACE listing (using SMF data) of all CD-MMIS production jobs executed during the month. The report shall provide the following detailed

information for each job: job name, date and time of job run, elapsed time of each job; condition code, CPU usage, I/O usage, output lines and form types, number of tape mounts or cartridges loaded, and restart/rerun indication. The Department has the option to require that the data be transmitted on electronic media;

viii. A PACE listing showing CD-MMIS CPU usage during the prior month in relation to the total CPU usage;

ix. A documentation checklist that indicates which items were changed during the month; and

x. A Program Inventory List. This list shall contain a comprehensive list of all CD-MMIS programs, grouped by subsystem or application. Details shall include: program name and brief description, program interfaces (inputs and outputs), last date of program update, and ChangeMan level stamp.

14.2.20.2 QUARTERLY DELIVERABLES

The Contractor shall deliver the items listed below to the Department by the tenth (10^{th}) State workday after the end of each quarter:

1) A summary report of all system abnormal terminations (computer operations trouble report) that identifies the problem program and resolution. The report shall separately list all Problem Statements issued because of problems encountered and indicate whether an erroneous payment may have occurred. The report must also include a list of all application programs modified in order to resolve the problems;

2) A summary report of all production programs, JCL, and control card libraries that were modified and migrated into the production library;

3) A user documentation report listing all user documentation and all subsequent changes developed under this contract and their last change date. The report shall be produced in two (2) sequences, by user documentation and by change date;

4) An update of all user documentation (i.e., manuals). This update shall either state that no changes were made to the

manual or summarize any Department-approved changes that were incorporated during the prior quarter. The summarization, if any, shall include a brief description of the update, control number and revision date of the change to the manual; and

5) Records/File Summary Reports.

14.2.20.3 MEDIUM OF DELIVERABLES

The Contractor shall produce deliverables in one of four (4) mediums according to the following list. The Department may alter this list at its discretion:

1) Computer Representation (TAPE CARTRIDGE) of:

   a) CD-MMIS Program Source Code;

   b) CD-MMIS Production JCL;

   c) All ++INCLUDE members;

   d) COBOL representation of all CICS screens (IEBCOPY format); and

   e) Representation of CD-MMIS data files.

2) Microfiche/scanned and hard copy (paper) of all CD-MMIS production reports;

3) Hardcopy (paper) format for all of the following:

   a) General system designs;

   b) Detailed program designs;

   c) Detailed program specifications;

   d) Report descriptions;

   e) Screen descriptions;

   f) Computer operation procedures;

   g) Data descriptions;

   h) User documentation;

   i) Hardware/Software documentation; and

i) Table Layout descriptions.

4) Compact Disk (CD) format may be requested for any of the deliverables listed above.

14.2.20.4 DELIVERABLE EVALUATION

The Contractor shall upon implementation of any changes deliver all required documentation and the current version of the programs, JCL, ++INCLUDE members, and screen members that were modified as a result of the change. These deliverables shall be evaluated for completeness and timeliness, and shall be evaluated against the established standards using appropriate standard checklist(s).

1) Deliverables shall be determined to be complete if all of the following requirements have been met:

   a) A copy is received of every CD-MMIS program, and/or JCL, and/or ++INCLUDE members that was migrated into the production library;

   b) A documentation checklist is received for every CD-MMIS program, and/or JCL, and/or ++INCLUDE members that was implemented;

   c) All documentation received has been indicated on the documentation checklist;

   d) All ChangeMan level number changes are reflected in CD-MMIS programs, ++INCLUDE members, and/or JCL received; and

   e) Program modifications due to production “abends” are reflected in CD-MMIS programs received.

2) Program modifications shall be determined complete only if all the following requirements are met:

   a) CD-MMIS program code standards are followed; and

   b) The change to the CD-MMIS program code is a major change and that other items of documentation will be updated in conjunction with the implemented program change.

3) Received documentation checklist(s) shall be evaluated against the change reviews. ChangeMan level number changes will also be reviewed against the checklist(s);

4) Timeliness of the documentation shall be determined only when all of the following items have been received by the Department:

   a) All documentation identified on the documentation checklist(s) is delivered by the fifth (5th) State Workday of each month; and

   b) All programs/JCL/++INCLUDE members received have a related documentation checklist.

5) All documentation shall have a standard checklist. The received documentation will be evaluated against this checklist and will either pass or fail when reviewed against the standards reflected on the checklist.

14.2.21 SPECIAL REQUESTS

The Contractor shall provide the following to the Department upon request:

1) Additional reports to support the documentation collection activities. This request must be within the framework of the monthly and quarterly deliverables. The Contractor shall produce such reports with the next monthly cycle; and

2) A complete set of documentation. This documentation must reflect all changes made to any CD-MMIS program to date. The Contractor shall produce the documentation with the next monthly cycle. A complete set of documentation will be required no more than twice each contract year.

14.2.22 COMMUNICATION STANDARDS

In developing formats and protocols for communicating electronically with providers and other third (3rd) party payers the Contractor shall use nationally accepted formats and standards that meet its needs.

14.3 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Verify that all documentation produced by the Contractor conforms to the CD-MMIS standards;

2) Verify that programs and JCL produced conform to the CD-MMIS program code and JCL standards;

3) Revise the data processing standards when necessary;

4) Prepare data processing standards/documentation checklists for each standard;

5) Approve if acceptable, standards and structured techniques proposed by the Contractor;

6) Approve if acceptable exceptions, to the data processing standards requested by the contractor;

7) Verify all hardware is IBM plug-compatible and meets Department requirements; and

8) Verify the microfiche and microfilming deliverables meet established standards.

15.0 QUALITY MANAGEMENT OPERATIONS

15.1 OVERVIEW

Quality Management (QM) shall be a separate and centrally located management operation reporting directly to the Contractor Representative. QM shall be responsible for the measurement and review of the Contractor's overall performance within each area of contract responsibility; will interface with Department monitoring activities; will report to both the Contracting Officer and the Department simultaneously regarding compliance; and will oversee all resulting corrective actions required to ensure contract compliance.

15.2 OBJECTIVES

Objectives of the QM Operations include but are not limited to:

1) Retrospective measurements and reporting of system performance;

2) Prospective reviews and recommendations to the Contractor and the Department on program policies and/or procedures;

3) Identification and tracking of CD-MMIS system operations, and/or performance problems, and subsequent development and implementation of corrective actions necessary to remedy such problems; and

4) Communication and dissemination of quality assurance and improvement information throughout all levels of Contractor operations and concurrently to the Contracting Officer.

15.3 ASSUMPTIONS AND CONSTRAINTS

The QM Operation is subject to the following assumptions and constraints:

1) The QM Plan included in the Contractor's technical proposal shall be updated annually and is subject to Department review and approval;

2) The Quality Assurance Standards and Procedures Manual shall be submitted to the Department three months after contract effective date and updated on a quarterly basis thereafter;

3) All QM procedures and quality assurance standards shall be formally documented in the QM manual and made available to the Contractor's staff and the Department;

4) The Department may request the Contractor to conduct special quality assurance studies which should not exceed twenty-four (24) requests per calendar year; and

5) The Department and/or their authorized representative shall have complete CD-MMIS access to perform live test transactions for monitoring, reviewing, and testing the Contractor's operations;

15.4 CONTRACTOR RESPONSIBILITIES

The Contractor shall establish a comprehensive QM process to ensure contractual requirements are met, that internal processes ensure timely, accurate, effective and efficient processing of TARs and claims and all other documents, and that provider needs are met. The Contractor's QM process shall comply with ISO 9002 standards upon contract implementation and shall be certified to ISO 9002 standards within one (1) year of the operations period.

15.4.1 QUALITY MANAGEMENT PLAN

The Contractor shall:

1) Develop and annually update the QM Plan, which describes the methods to be used by the Contractor to ensure contract compliance and continuous quality improvement;

2) Ensure the plan shall identify and fully document the following:

   a) The quality management organizational structure;

   b) Those data sampling tools and procedures used to evaluate Contractor operations;

   c) The preventive measures used to identify, research, report and correct problems which, if resolved, would increase the efficiency and accuracy of CD-MMIS operations;

   d) The procedures used to evaluate and improve staff performance; and

e) The communication processes within the Contractor's organization and between Contractor and Department.

All annual updates to the QM Plan are subject to Department review and approval. Should there be delays in securing Department approval of the annual update, the Contractor shall continue to adhere to the QM requirements contained in the latest approved QM Plan.

15.4.2 QUALITY ASSURANCE STANDARDS AND PROCEDURES

The Contractor shall:

1) Formally document all quality management procedures and internal quality assurance standards in a Quality Assurance Standards and Procedures Manual to be made available to its employees and the Department;

2) Ensure the manual be submitted to the Department three (3) months after the contract effective date and shall be updated on a quarterly basis thereafter;

3) Design and maintain the manual to encourage maximum employee usage;

4) Ensure the manual contain all policies, procedures, mathematical formulas and calculations used in the monitoring of internal performance standards and error rate limits for employees in each area of the Contractor's Operations that affects the accuracy of document processing; and

5) Ensure the manual be incorporated into everyday operations of all Contractor work functions responsible for the processing of Adjudicated documents. The manual shall be made available to all new employees as a training and reference tool in the applicable Contractor's operations.

15.4.3 QUALITY MANAGEMENT REVIEWS

The Contractor's QM program shall:

1) Include concurrent and retrospective reviews of contract work to determine the Contractor's compliance with all contract requirements;

2) In addition to the review for compliance, monitor the Contractor's performance in meeting internal quality

assurance standards. The Contractor shall set these internal quality assurance standards for accuracy and timeliness for each task and work location used to meet overall contract requirements;

3) Ensure the methods to monitor system performance shall include but are not limited to the following:

   a) Sample testing of adjudicated documents (e.g., claims/TARs/NOAs/CIFs) and eligibility verification responses;

   b) Regularly schedule audits of document processing functions; and computer-generated performance reports;

   c) Ensure these actions be run on a systematic schedule to determine the reliability of the CD-MMIS in meeting contract requirements and accuracy in document adjudication;

   d) Ensure all sampling must ensure statistical reliability at a ninety-five percent (95%) confidence level;

   e) Ensure the method for testing be fully explained in the Contractor's QM Plan, and incorporated in step-by-step detail in the Contractor's Quality Assurance Standards and Procedures Manual;

   f) Ensure that not only report errors found in the system, but also shall project those errors into overall error rates separately for over and underpayments for the sampled area, and translate these errors into dollar amounts separately for over and underpayments and error types.

The Contractor shall not attribute errors to being a "human error" but shall provide additional review and research of the processes used in CD-MMIS to determine the cause of the error(s) and develop the systematic means to reduce these errors.

15.4.4 QUALITY MANAGEMENT (QM) ACTIVITIES

Monthly QM activities shall include testing and review results on the following system functions:

1) Cycle time as defined in Exhibit A, Attachment I, Takeover;

2) TAR processing;

3) Claims/NOAs processing;

4) Suspense processing;

5) Replace and Substitute processing;

6) Professional and paraprofessional review;

7) Manual pricing;

8) File update, including reference, recipient, provider, payment, MARS, and S/URS;

9) Manual and system documentation updates;

10) Accuracy review of four (4) different edits and audits, to be defined by the Department fifteen (15) State workdays before the month to be reviewed;

11) Microfilm and microfiche quality of Computer Output Microfilm (COM) (Exhibit A, Attachment I, Takeover);

12) Hard copy reproduction of microfilm and microfiche versions of new claims payment records (less than ten (10) State workdays from the initial reproduction on microfilm or microfiche);

13) CIF processing; and

14) Appeal processing.

Reviews of other areas shall be done no less than once every six (6) months. The Contractor's QM Plan shall list each area of contract responsibility required during operations, and include schedules and specific methods to monitor system performance for each area.

The Department shall have the authority to review and approve these schedules and methods throughout the life of the contract.

15.4.5 PAYMENT FILES REVIEW PRIOR TO CHECK PRODUCTION

The Contractor shall

1) Describe in the QM Plan its system for the review of provider payment files prior to performing the checkwrite function since the Contractor is responsible for assuring that the payment process is accurate prior to issuing checks to providers. This may include submitting the payment tape through a series of edits/audits to detect errors;

2) Perform a quality management review of each payment tape to detect errors in payment not detected in routine processing including the pre-checkwrite function.

   QM review shall include the use of computerized reports to detect potential errors, including payments in excess or under allowable amounts and payments in excess of established amounts as defined by the Department, and manual review of all exceptions to determine if they are in error;

3) Notify the Department of any errors prior to the release of checks. For claims found to be in error, identify the error in a Problem Statement, reprocess the claims, and make adjustments as necessary. Processing times shall be the same as those specified for Weekly Checkwrite Reviews, as follows:

   b) Adjustments

      Weekly Checkwrite Reviews

      i. To minimize the delay in issuing payment to a provider when the Contractor retains a provider check for review and/or lists claims, the Contractor shall reschedule for payment those claims within the retained check or list of claims that do not contain errors. The rescheduled payment shall be made either within seven (7) State workdays or by the next checkwrite following the date the Contractor notifies the Contracting Officer, whichever period is shorter;

      ii. All corrections and rescheduling of corrected provider payments shall be completed within thirty (30) calendar days of notification to the Contracting Officer, unless additional time is granted by the Contracting Officer. When the Contracting Officer grants additional time, and within three (3) State workdays of the approval notice, the affected provider(s) shall be notified in writing of the claims in question; and

      iii. Upon completion of the corrections and rescheduling of the thirty (300 calendar days, whichever is less, the Contractor shall notify the Contracting Officer in writing of the completed transaction(s). Where extended time has been authorized, the Contractor shall again notify the Contracting Officer in writing of the completed

transactions by the end of the extension period or completion of corrections and rescheduling of provider payments, whichever occurs first (1st). All notices shall include date(s) of completion and rescheduled payment(s).

b) Returned Checks

The Contractor shall be responsible for the receipt, processing and adjustment to history of all repayments submitted by providers, (e.g., offset for overpayment received from an outside source). In addition, the Contractor shall process provider-initiated adjustments. The Contractor may receive returned payments in several forms:

i. Returned check - The provider does not cash and returns the actual check(s);

ii. Personal check - The provider cashed the check but returns a personal check with the Contractor's claim payment documentation (EOB);

iii. Personal check without supporting documentation (EOB) - In this instance the Contractor shall contact the provider to determine any unidentified claim(s) needing adjustment; and

iv. Requested adjustment - The provider cashes the check but requests by a CIF that his/her next payment(s) be adjusted accordingly.

Within five (5) State workdays of receipt of a returned provider payment check or personal check, the Contractor shall notify the provider in writing that the payment has been received. The written acknowledgment shall also inform the provider that a follow-up letter shall be sent within forty-five (45) calendar days of receipt of provider's returned payment/check. The follow-up letter shall include what specific action(s) were taken regarding the provider's returned check.

The Contractor shall process all adjustments and correct all related files and records, including the six (6) week Provider Paid History File and the seventy-two (72) Month History File, in no more than thirty (30) calendar days of receiving a provider's returned payment and in accordance with the policies and procedures established in the Financial Management Manual. If resolution of the problem is so complex or

voluminous that additional time is required, the Contractor shall request approval in writing from the Contracting Officer. Whenever an extension is granted, the affected providers shall be so notified;

c) Erroneous Payment Corrections

The Contractor shall correct all erroneous payments to providers and adjust its records regardless of the cause or the source of the erroneous payment. Other adjustment requirements are described in Claim Payment Responsibilities.

Problem Statements related to erroneous payment corrections will be submitted to the QM Operations by Department or Contractor staff unless the Department determines that immediate action is required and submits the Problem Statement directly to the Contractor's Systems Group (SG) for action. The QM Operations shall have responsibility to ensure that all Problem Statements related to erroneous payment corrections are processed by the SG within the timeframes as described in the following Problem Correction System requirements;

d) Liability for Overpayment

The Contractor is liable to the Department for unrecoverable overpayments and any associated administrative expenses. Unrecoverable overpayments are erroneous payments caused by the Contractor where the Department and the Contractor are unable to collect. Below are examples of what the Department considers unrecoverable overpayments:

i. Erroneous payment whereby the overpayment cannot be collected from the provider due to the Contractor's negligence or inaction;

ii. Erroneous payment for claims paid to a provider who was inappropriately enrolled in the Medi-Cal Dental Program;

iii. Erroneous payments caused by the Contractor where the Department and the Contractor are unable to collect from the provider; and

iv. Those erroneous payments for claims processed when a beneficiary's eligibility would preclude reimbursement for services through CD-MMIS,

e.g., the beneficiary is enrolled in a dental managed care plan.

15.4.6 PROBLEM CORRECTION SYSTEM (PCS)

The Contractor shall:

1) Employ a problem correction system (PCS) for tracking and reporting problems. The Contractor, upon prior Department approval, may use a system such as Enterprise Project Management (EPM), or any other equivalent software product that would offer significant enhancements as well as meet the requirements for PCS and the reporting capabilities of EPM. The Department shall have on-line read and update access to this data, and shall receive the data on electronic media and paper. The Contractor's PCS and reporting shall be fully defined and documented in the Quality Management (QM) Plan;

2) Utilize the PCS as the sole means of identifying and tracking problems identified by either Department or Contractor staff in response to problems related to CD-MMIS Operations. The Contractor shall ensure QM staff receives and tracks all problem statements (PSs) using the PCS, and all PS processing timeframes are met in accordance with the timeframes outlined in the Problem Correction System Timeliness Requirements section;

3) Maintain a joint PCS tracking and reporting system that shall be used as a tool to document the status of all PSs to final resolution. This system shall generate the PCS weekly status reports;

4) Update the PCS within one (1) State workday of every action performed (e.g., interim response submitted to the Department);

5) Correct all deficiencies identified through the PCS;

6) Ensure all documentation in the PCS is typed or computer-printed so as to be legible, and written to facilitate the interpretation of the documentation at a seventh (7^{th})-grade reading level;

7) Ensure Contractor-initiated PSs contain, at a minimum, all elements used in the Department's CD-MMIS Problem Statement form (copy available in the Office of Medi-Cal Procurement Data Library);

8) Develop and maintain procedures to initiate, receive, process, track, and report all PSs issued by the Department and/or Contractor staff. The procedures shall explain the step-by-step methods of processing PSs and shall address how QM staff shall meet all requirements. These procedures must be included in the Quality Assurance Procedures and Standards Manual;

9) Hold weekly PCS status meetings to discuss the status of all open PSs. The Contractor shall provide the written PS Status Report identifying the status of any and all open PSs that have exceeded the PS processing timeframes. The report shall provide a listing of each PS exceeding the processing time frame(s), a statement of why each PS has exceeded the time frame(s), an estimate of hours required to resolve each PS, and the estimated date by which each PS will be resolved;

10) Forward the weekly PCS status reports to the Department by Wednesday of each week. If the Department disapproves any of the information provided on the report, the Contractor shall make the necessary corrections and provide the revised report to the Department within five (5) calendar days of the date the report was disapproved. If within five (5) days, the corrected report is not received, the Department will be excused from payment of such report. These status reports shall include:

    a) Open Problem Statements Sorted by PS Number;

    b) Open Problem Statements Sorted by SG Project Manager and, secondarily, by the effected subsystem, (e.g., Provider, Recipient, References, S/URS);

    c) Open Problem Statements Sorted by Priority;

    d) Problem Statement Weekly Summary;

    e) Open EPC Problem Statements Sorted by EPC Number;

    f) Open EPC Problem Statements Sorted by SG Manager and the effected subsystem;

    g) Open EPC Problem Statements Sorted by Priority;

    h) EPC Problem Statements Weekly Summary;

    i) Contractor’s Problem Statements Aged Summary;

    j) Department’s Problem Statements Aged Summary;

k) Interim Responses Overdue Detail; and

l) Open Problem Statements Aged Summary.

11) Document to the Department, in a PS, any and all CD-MMIS problems identified by Contractor staff within two (2) State workdays of identification. The PS shall identify any potential mispayments; and

12) Prepare bulletins or letters to providers to advise them of the erroneous payment correction reprocessing/adjusting-taking place. The Contractor shall adhere to all publication requirements when preparing and processing provider bulletins/letters.

15.4.6.1 PROBLEM CORRECTION SYSTEM (PCS) PROCEDURES

The Contractor shall:

1) Maintain and update the PCS to receive, process, track, and report on all PSs issued by Department and Contractor staff. Department staff shall have inquiry capability to the PCS, and update capability will be strictly limited to Contractor's QM staff, SG staff, and identified Department staff;

2) Ensure the PCS procedures follow the processing steps in the order listed below and meet all processing requirements:

Problem Statements (PS) are statements that identify problems or errors within CD-MMIS Operations:

a) Problem statements shall be used by the Department and Contractor staff for documenting all problems identified. The PSs are written to provide the Contractor with the identification of a potential problem with supporting data to initiate evaluation and resolution of each problem within the Contractor's Operation of CD-MMIS. Problem Statements are not payable until after the Contractor has obtained Department approval of the Interim Response. If it is determined that an erroneous payment situation has occurred, this shall be identified;

b) The Contracting Officer shall assign the priority level for all PSs and may adjust the priority at any time, including those for PSs already in the system;

c) The Department may assign any PSs directly to Systems Group for immediate action without requiring QM staff to generate an interim response; and

d) QM staff shall input all PSs onto the on-line PCS and submit Contractor-generated PSs in writing to the Department within two (2) State workdays of identification of any and all problems.

3) An Interim Response is a preliminary analysis, priority designation, and identification of where the problem exists within the system.

a) QM shall prepare an interim response for each PS within fifteen (15) days of issuance of the PS and shall forward it to the Department. The Contracting Officer may close the Problem Statement, disapprove or request modifications to the Interim Responses;

b) The interim response shall provide an estimate of the scope of the problem based upon a preliminary analysis of the problem, a listing of the programs affected, identification of where the problem exists within the system, and resolution location (i.e., Systems Group or QM); and

c) If the PS is an erroneous payment, the interim response shall provide the following information:

i. Definition of the scope of the erroneous payment; and

ii. Determination if the error or set of errors is isolated or resulting from a systematic or manual procedure problem.

4) Ensure problem statements for erroneous payments be routed with the interim response to QM for resolution.

5) QM staff shall identify and input into the PCS the resolution location. The Systems Group staff shall handle all problems that require program changes, QM Unit shall handle all problems that require an EPC (except when an EPC is required to make a rate change), and QM staff shall handle all problems that require manual changes.

a) Problems that shall be retained by Systems Group include situations that require changes to the applications programs, programming, and any EPC that is required to make a rate change;

b) Problems that shall be retained by the QM include situations that require operation of an erroneous payment correction system which shall be utilized for reprocessing of claims where computerized history searches are necessary to select large volumes of claims that have been improperly paid, and situations that resulted in mispayment of claims (e.g., error not detected through the system test environment, manual keying errors); and

c) QM shall forward the PS and interim response with all background documentation to the responsible unit for resolution, concurrent with the submission of the interim response to the Department.

6) Utilize Corrective Action Plans (CAP) to provide a complete analysis of the problem and identify the action steps and timeframes necessary to correct the problem:

a) QM shall prepare a CAP and forward the CAP to the Department for approval within thirty (30) days of submission of the PS. The CAP shall include, but is not limited to, the following elements:

i. Background with a description of the problem;

ii. Description of the cause of the error and the correction needed;

iii. Detailed analysis of the error situation and its source;

iv. Description of how QM intends to correct the error or eliminate the error pattern or deficiency to include correction of all program or procedural problems;

v. Estimated date of correction;

vi. Deliverable requirements/approvals;

vii. Erroneous Payment Correction (EPC);

viii. General functional requirements;

viii. Any special instructions;

ix. A work plan consisting of major milestones, the dates by which each general functional requirement is expected to be completed, and the

resources needed to complete them. The work plan shall include timeframes with estimated start dates and completion dates, and also include scheduling of timelines for Department review and approval. The work plan shall meet the requirements in the General Terms and Conditions section for Contractor Work Plans. If the Contractor determines that a work plan is not necessary, the Contractor shall submit a request in writing to the Department justifying the request for relief from the work plan requirement; The work plan shall include an estimated breakdown of hours to be applied to the project, designated by task (e.g., development, coding, acceptance testing, systems testing);

x. Contact person(s) and the staff person(s) assigned; and;

xi. Signature of an authorized representative of the Contractor.

7) Correction Notices (CN) confirm correction of the problem. The Contractor shall prepare a CN and forward it to the Department for approval. The CN shall include the following information:

a) PS number;

b) Description of the problem identified in the PS;

c) Description of the modification(s) made to correct the problem including:

i. Analysis of the situation;

ii. Evidence validating the modification(s) (i.e. copies of the testing results (mandatory prior to approval of closure);

iii. Specific program(s) and manual procedure(s) that were modified; and

iv. The date the modification(s) was installed into production status.

d) Whether the PS was Contractor-generated and, if so, a statement from the initiator or representative from the initiating area, verifying that all modifications have been reviewed and confirming that the problem has been fixed;

e) Whether the PS applies to claims or other situations not described in the PS;

f) Source of the problem (e.g., SDN enhancement, examiner error, table update) or a statement that the system is operating as designed;

g) Whether any CD-MMIS documentation needs to be updated or created to document the modification(s). This documentation must be included with the CAP/correction notice;

h) Whether an SDN or DOIL is required to make further system modifications. A description of the modification(s) must be included with the notice;

i) Whether erroneous payments occurred as a result of the problem and, if so, include an identification of the selection criteria needed to perform the erroneous payment correction; and

j) Within thirty (30) days from submission of each correction notice, the Contractor shall update the Detail Design Specifications and all appropriate documentation.

15.4.6.2 PROBLEM CORRECTION SYSTEM TIMELINESS REQUIREMENTS

1) If the PS relates to a potential overpayment situation, the Contractor shall provide an interim response to the Department within five (5) State workdays of the PS;

2) For all other PSs, QM staff shall provide an interim response within fifteen (15) State workdays of issuance of the PS, a CAP within thirty (30) State workdays of issuance of the PS, and the CN within thirty (30) State workdays of Department approval of the CAP;

3) All PSs, interim responses, CAPs, and CNs shall be submitted to the Department for review and approval. If the document is disapproved by the Department, the Contractor shall have five (5)State workdays to correct the deficiency and resubmit the revised document to the Department for approval;

4) The Contracting Officer may identify PSs that require expeditious processing by the Contractor. These PSs shall be resolved within thirty (30) State workdays with

a CN submitted to the Department within five (5) State workdays of the resolution. The Contracting Officer may not require expeditious processing for more than sixty (60) PSs per year;

5) The Contracting Officer may extend any of these timeframes on a request-by-request basis and only in writing. The Contractor shall submit a written request to the Department that documents the work performed to date, the reason such an extension is necessary, and the targeted completion date; and

6) The Department shall have a minimum of thirty (30) State workdays to approve the CN.

15.4.7 ACCEPTANCE TEST FACILITY

The Department will utilize live test transactions to aid and enhance monitoring of the Contractor's performance. This will include the establishment by the Department of test providers and beneficiaries on production files, as well as the submission of test data including claims, TARs, NOAs, RTDs, CIFs, and other documents, without limitation and as necessary, into the production system. The Department will utilize this process without notice to the Contractor to assure that the test replicates outcomes to be expected in a live environment. This facility may be made available to the Contractor with approval of the Contracting Officer.

15.4.7.1 ACCEPTANCE TEST SYSTEM

The Contractor shall:

1) Aid the Department in monitoring the system's accuracy, the Department will utilize live transactions to test the Contractor's performance. This will include the establishment, by the Department, of test providers and beneficiaries on production files, as well as the submission of test data, including TARs, RTDs, CIFs, claims, and inquiries to the production system. The Department will utilize the live-transaction testing process without notice to the Contractor, to assure that the test replicates results expected in the production environment;

2) Ensure the CD-MMIS operates according to federal and State regulations and statutes, it is imperative that the Contractor maintains an acceptance test environment, and fully test system changes prior to implementation in the production environment. The acceptance test system is an

environment used to test system changes before promoting those changes into the production system. The environment shall include a test (mirror) version of on-line and batch programs and system files that are identical to the production environment;

3) Continue to perform comprehensive Acceptance Testing to ensure that system changes to CD-MMIS initiated by any change instruments (e.g. SDNs, MCDs, DOILs, or previous implemented problem statements) will be correctly installed into the production environment;

4) Execute all Acceptance Testing as part of the Department's ongoing monitoring of SG testing. This is necessary to ensure that State and federal goals for accuracy, efficiency, and policy conformance are met;

5) Provide a separate test environment for Acceptance Testing purposes;

6) Operate and maintain a complete and current on-line test system, including a test version of batch and on-line programs and test tables and files. At a minimum, the test data shall include a true reflection of daily, weekly, monthly and semi-monthly volumes of claims data;

7) Identify providers, recipients, and claims used for testing to maintain the integrity of routine claims processing operations and files;

8) Specify a migration schedule for program "fixes" from the System Test environment to the Acceptance Test environment and migrate only after Department approval;

9) Generate test output, including tables, files, reports, tapes, and micro media. Output shall be separately identified and clearly labeled. Test outputs shall be separate from routine CD-MMIS outputs and available to the Department during business hours within twenty-four (24) hours of the request;

10) Perform claims processing in a simulated production environment;

11) Provide the Department with on-line access to the test environment, test tables, and files; and submit test data independent of notice to the Contractor's testing team. Such access shall include the use of on-line terminals to access any CD-MMIS related data;

12) Accept test claims data submitted by the Department on hard copy or electronic media, without notice to the

Contractor's testing team (i.e., the Contractor is unaware that the test claims data have been submitted);

13) Permit the Department to observe the tests, analyze results, and document any problems;

14) Report on the results of test cycles, including the expected impact of edit and pricing changes, and compare those results to the actual processing results;

15) Respond to, and correct all problems identified by the Department. The Contractor shall repeat acceptance testing, until criteria defined by the Department are satisfied;

16) Upon satisfactory completion of acceptance testing, the Department shall approve and retain Acceptance Test documentation. The Department may approve phrases and require additional testing of remaining functions;

17) Initiate and conduct a walk-through of system test changes that are ready to be moved into the production environment. Walk-through of test cases and results shall include a discussion of programs that are impacted by the system change. The Contractor shall include an on-line demonstration verifying the accuracy of system changes and handouts of test results. Walk-through materials will be conducted for system changes involving major modifications, or where a significant number of programs and/or files are modified when directed to do so by the Department;

18) Deliver or make available to the Department all Acceptance Test documentation, including files and reports necessary to validate test results. These materials shall be provided to the Department no later than one (1) State working day following test execution. The Contractor shall provide the Department each week with a list of such test documentation;

19) Maintain open communication with the Department during Acceptance Testing, and shall provide walkthroughs to Department staff, on specified test, upon request;

20) Develop and execute Department-approved test cases for system changes;

21) Maintain acceptance test facility activities, tables, files, and data elements necessary to meet Department requirements and simulate production;

22) Produce and review control reports generated for each test update and processing cycle;

23) Ensure acceptance testing shall continue until all testing System Variance Reports (SVRs) identified during Acceptance Testing have been resolved. The Contractor shall provide all necessary support for Acceptance Testing during this period. The Department shall prioritize any problems identified by these tests. The Systems Group shall correct deficiencies determined by the Department. Otherwise, the Contractor shall be responsible for correcting the deficiency;

24) Perform volume and stress tests, and the parallel test as directed by the Department, to demonstrate the ability to process expected CD-MMIS workloads accurately within prescribed timeframes as described in Exhibit A, Attachment III, Change Requirements;

25) Ensure where resources permit, tests be scheduled concurrently so that Acceptance Testing can progress more rapidly; and

26) Submit its bid based on the Department relying heavily upon the two parallel tests and a detailed analysis of the results by the Contractor and minimal Department submission of test claims.

15.4.7.2 ACCEPTANCE TESTING UNIT

The Contractor shall:

1) Employ staff as members of an Acceptance Testing Unit that shall be separate from the Systems Group (SG). This unit shall be responsible for developing test plans and test cases to ensure all CD-MMIS processing is accurate and complete. This unit shall be responsible for:

   a) Testing all CD-MMIS changes and table updates prior to their implementation; and

   b) The resolution of all EPCs due to errors caused by system changes and table updates that are implemented incorrectly by the Contractor (e.g., keying errors, inadequate testing, inadequate quality review, programming errors).

2) Develop and implement a testing environment and the methodologies required to ensure that testing verifies that all components process successfully, and independently of each other, and ensures that all manual and automated processing are compatible with system changes and table updates;

3) Correct all PS and process all EPCs due to errors caused by system changes that are implemented incorrectly;

4) Ensure an adequate number of staff is available to perform all testing, and ensure the testing is complete and accurate. It is anticipated that, at a minimum, the following full-time equivalent (FTE) staff will be necessary:

   a) One (1) FTE Project Manager;

   b) Two (2) FTE System Analyst;

   c) Two (2) FTE Business Analyst; and

   d) One (1) FTE Documentation Specialist.

   This staff shall be separate from the 30 SG staff.

4) Ensure staff with appropriate classifications and training to support CD-MMIS testing be in place prior to the start of Department Acceptance Testing. Supervisory, management, or technical staff may not be used for manual processing activities;

5) Require staff to demonstrate adequate proficiency in performing assigned tasks. The Department will prepare a checklist of CD-MMIS tasks to be demonstrated; and

6) Ensure staff employed in the testing team is knowledgeable in dental claims processing, and familiar with all the components of CD-MMIS (i.e., all the manual and automated processes to process a claim through CD-MMIS) including the TAR process, in order to adjudicate a claim and process payment.

15.4.8 ACCESS TO CD-MMIS

The Contractor shall maintain an Automated Methods and Procedures Plan that shall describe procedures for access to CD-MMIS. The purpose of this access shall include, but not be limited to the following functions:

1) Provide access for the Department to all Contractor research techniques including, at a minimum, the ability to request dumps of input or process data at each step in the claims processing or reporting procedure;

2) Provide access for Department monitoring staff to validate all tests run by the Contractor. The Contractor shall provide any of the test run format or documentation to Department

staff for duplicate monitoring in order to validate the Contractor's test results;

3) Provide the Department, upon request, with a copy of any CD-MMIS data file, including the MMIS tables file (UTF001) and all other Reference files. Unless otherwise specified in Exhibit A, Attachment II, Operations, Operations Requirements, the Contractor will be reimbursed for this expense on an hourly reimbursement basis;

4) Ensure access availability of the entire CD-MMIS to Department or Department-contracted monitoring staff for testing. The Department will have authority to test the CD-MMIS production system to ascertain that changes have been installed correctly and policy is being executed as required;

5) Provide the means for the Department to generate random samples of claims, TARs, NOAs, or RTDs at any stage of claims processing;

6) Provide the means for the Department to measure overall staff and system performance in claims and TAR processing from input preparation to final adjudication; and

7) Provide the Department with access to Contractor working papers used in the production of quality management reports.

15.4.9 INFORMATION SECURITY OFFICER

The Contractor shall, for the life of the contract, establish a position of Information Security Officer (ISO). The ISO shall report directly to the Project Director and shall be provided needed administrative support, including clerical. The ISO provides oversight of the Contractor's information security program and conduct reviews of the Contractor's operations (to include internal financial controls and contractor employee system access and rights) on an ongoing basis to prevent and detect fraud. This program encompasses all sensitive systems (i.e., automated and manual, physical and logical). It includes the policies, procedures, guidelines, and safeguards that are required to protect data confidentiality and privacy rights, and ensure the integrity and availability of these information systems. Typical duties shall include:

1) Develop security policies, procedures, and criteria for the collection, storage, access, and destruction of information assets. The policies and procedures provide the operational guidelines and delineate roles and responsibilities of

Contractor's entities for assuring the security and integrity of information assets;

2) Provide technical assistance to Contractor personnel to determine the need and appropriateness of proposed security provisions and review proposed modifications to existing electronic information processing systems to ensure appropriate security safeguards are maintained;

3) Develop policies and procedures for reporting incidents involving intentional, unintentional or unauthorized use, modification, access, or destruction of Contractor's information assets. Coordinate with and assist Audits & Investigations Division during investigations of alleged incidents of security and/or fraud violations;

4) Analyze legislation, Federal and State mandates as well as other rules and regulations for their effect on security policies and ensure Contractor compliance;

5) Evaluate requests for release of personal/confidential information requests based on existing laws, regulations and policy and procedures, and make recommendations to the Department;

6) Conduct risk assessments to identify potential vulnerabilities that could threaten the security of the Contractor's information assets and areas for potential fraudulent activities. These reviews provide an independent assessment of the effectiveness of security systems and compliance with laws, regulations, polices, and procedures;

7) Ensure the recoverability of CD-MMIS systems by participating in the development, implementation, testing, and maintenance of the Contractor's Operational Recovery Plans; which is designed to allow effective and efficient recovery of business functions in the event of a disaster;

8) Develop and oversee the Contractor's virus protection program;

9) Develop and oversee the Security Awareness Program for all Contractors' employees, technical staff and Management;

10) Conduct special reviews as requested by the Department; and

11) Provide written and oral presentations of review issues to Department staff.

15.4.10 AVAILABILITY TO THE DEPARTMENT

The Contractor shall provide to the Department or a Department-monitoring contractor, access to CD-MMIS for monitoring, reviewing, and testing of the Contractor's Operations. The Contractor shall maintain the Automated Methods and Procedures Plan that describes procedures for this access.

15.4.11 PERFORMANCE MEASUREMENT

15.4.11.1 INDIVIDUAL EMPLOYEE PERFORMANCE

The objectives of the employee performance review process are to:

1) Ensure an acceptable level of manual production quality;

2) Reduce error through systematic auditing within a production unit;

3) Provide comparison between quality performance and quantity of work produced; and

4) Provide documentation for employee training.

The resource management system established by the Contractor to perform periodic evaluations of employees shall be designed to monitor and improve the quantity and quality of employee output with actual results being measurable. The system shall be centrally located to retrieve and analyze employee output reports. The management system shall detail areas of problems and potential inefficiencies that can be incorporated into performance evaluations to emphasize low error rate with high productivity. The QM staff involved in the resource management function shall be available to advise and assist in training for particular staff or work units where reported problems and inefficiency trends are indicated.

Performance testing procedures shall be defined in the Contractor’s Quality Assurance Standards and Procedures Manual and shall include the procedures in which the Contractor is to report once a month to the Contracting Officer on the outcome of performance testing. These reports shall describe the Contractor’s efforts, studies performed by area, overall results found (by employee and in the aggregate), and corrective actions taken, if applicable. Reports on employee performance evaluations shall be delivered to the Department no later than thirty (30) calendar days following the end of the report month.

On a monthly basis, there shall be a performance, productivity and accuracy evaluation completed by the Quality Management Dental Consultant (QMDC), on each Dental Consultant, including Clinical Screening Dentists.

The Contractor shall:

1) Perform periodic evaluations of each individual employee's effectiveness and accuracy in every CD-MMIS operations area by sample testing the performance of individual staff for errors and trends, specific to each work operation. This system shall be used to evaluate performance, productivity and accuracy of work performed in all areas of Contractor responsibilities, including but not limited to document processing and adjudication, data entry, computer operations, programming, payment activities, provider relations, expert witness, and cost reimbursement. While individual employee assessment is a function of the immediate supervisor, the Contractor's QM program shall monitor this effort and include an evaluation of individual employee performance in its scope of review;

2) Ensure all Contractor staff, including but no limited to professionals and paraprofessionals, have access to the most current and up-to-date copies of all manuals and references appropriate and necessary for the performance of their duties; and

3) Ensure the QM unit shall establish and maintain a resource management method designed to provide continuous monitoring and measurement of the quantity and quality of employee production.

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15.4.12 ORGANIZATION AND STAFFING

The Contractor shall employ a QMDC, reporting to the Director of QM, whose responsibility is to monitor the training and professional competency of the Contractor's Dental Consultants and Clinical Screening Dentists. The QMDC is a dedicated position to be used solely for this function and cannot be used in the processing of documents to meet cycle time requirements.

The QMDC shall:

1) Hold a current, active, and unrestricted license to practice dentistry within the State of California and have a minimum of five (5) years of clinical experience;

2) Have had a minimum of two (2) years of activity in a formal body responsible: 1) for the review of standards of care or practice parameters; or 2) for the determination of clinical quality of care;

3) Have the full-time support of at least one (1) QM program staff. This individual shall complete formal auditor training and shall have a minimum of one (1) year of experience in the paraprofessional adjudication of claims/TARs/NOAs prior to full-time assignment to the QMDC;

4) Monitor all Dental Consultant and Clinical Screening dentists' training;

5) Ensure that each individual Dental Consultant has at all times, in his/her immediate work area, at a minimum, a Medi-Cal Dental Program Provider Manual (with bulletins), a Professional & Paraprofessional Adjudication Manual, a Code Manual, a Suspense & Error/File Maintenance Processing Manual and a Clinical Screening Dentist Manual. In addition, each Dental Consultant's manual shall contain the most current update/revision pages;

6) Monitor the quality performance of all Dental Consultants and Clinical Screening Dentists and record findings on a monthly Professional Review Productivity Report commencing ninety (90) calendar days after the start of operations. All Dental Consultants and Clinical Screening Dentists shall be reviewed monthly and reported on an individual basis. Each Dental Consultant and Clinical Screening Dentist shall be identified by the name appearing on his or her California dental license;

7) All QMDC reports shall be transmitted to the Department through the standard reporting procedures provided in this contract; however, all working papers used in preparation of the QMDC report shall be available to the Department upon request.

8) Maintain a system that tracks dental license expiration dates, and shall use this system to ensure that all Dental Consultants and Clinical Screening Dentists hold current, active, and unrestricted licenses to practice dentistry within the State of California.

9) Receive and maintain copies of any and all change documentation related to document adjudication policy and procedures, including but not limited to DOILs, SDNs, MCDs, Change Orders, and Exceptional Processing Instructions (EPIs).

10) Establish policies and procedures for measuring the quality of professional review and adjudication for each Dental Consultant and the quality of professional review for each Clinical Screening Dentist. In performing professional reviews, the QMDC shall:

    a) Ensure individual Dental Consultants maintain a minimum of a ninety-eight percent (98%) accuracy level in the professional adjudication of claims/TARs/NOAs, and for every Professional Review Data Control Center except the State Wait Data Control Center in accordance with Medi-Cal dental policy and procedures. EXCEPTION: Individual Dental Consultants involved in the adjudication of documents from providers on Prior Authorization/Special Claims Review status shall maintain a minimum of a ninety-nine percent (99%) accuracy level in the professional adjudication of claims/TARs/NOAs;

    b) Review a statistically valid sample of all Clinical Screening dentists reports and determines compliance with Medi-Cal dental policy and procedures. Errors will be entered on the Clinical Screening Dentist Report Worksheet, compiled in quarterly reports, and included in the Clinical Screening Dentist database; and

    c) Be responsible for the creation and execution of a corrective action plan for any Dental Consultant or Clinical Screening Dentist whose performance fails to meet contract requirements or quality management standards.

15.4.13 REPORTS

15.4.13.1 REPORTS REVIEW

The QM program shall include dedicated staff responsible for the coordination and evaluation of statistical reports. The responsibilities of staff shall include, but are not to be limited to:

1) Ensuring report quality of all reports by thoroughly reviewing and verifying report content and accuracy on an ongoing basis. The means and frequency shall be fully outlined in the Quality Assurance Standards and Procedure Manual;

2) Ensuring that timely report production and distribution, both internal and external, is verified through the review of distribution sheets/logs, and where necessary through monitoring of the production process;

3) Verifying/balancing all S/URS history file updates with an appropriate MARS and claims processing file and report;

4) Monitoring on-line response time and reliability; and

5) Providing full cooperation to the Department in clarifying ambiguities and correcting report deficiencies and discrepancies.

15.4.13.2 SIXTY (60) AND NINETY (90)-DAY EDIT REPORTS REVIEW

As part of the quality management function, QM staff shall research each claim listed on the ninety (90) Day Edit Report and each TAR on the sixty (60)-Day Edit Report. The purpose of this ongoing review is to determine the reason(s) for aged claims/TARs and expeditiously adjudicate them in order to reduce the volume in each category. The Contractor shall submit a weekly report to the Department outlining the reasons why specific claims and TARs are aged beyond the maximum time frame allowed. This report shall provide an extensive review of all related TARs below sixty (60)-days and claims/NOAs below ninety (90) days. This QM report shall be due and copy delivered to the Department fifteen (15) calendar days after the weekly sixty (60)/ninety (90)-day cycle time report.

15.4.13.3 SPECIAL QUALITY ASSURANCE STUDIES

The Contractor shall perform Department directed special quality assurance studies. These studies shall not exceed twenty-four (24) requests per calendar year. The Contractor shall develop the study method and submit it for Department approval within seven (7) workdays of receipt of the study request from the Department. The Contractor shall complete the study as directed and forward the findings to the Department within forty-five (45) calendar days of request.

15.4.13.4 MONTHLY QM PERFORMANCE REPORT

The Contractor shall:

1) Ensure that the Monthly QM Performance Report is accurate and complete and that all contract-required responsibilities are addressed;

2) Delivered the report to the Department no later than thirty (30) calendar days after the end of the report month;

3) Report on the outcome of the performance testing and deliver reports to the Department in three (3) increments:

   a) Computer based reports shall be delivered no later than the fifth (5^{th}) State workday following the end of the report month;

   b) All other reports shall be delivered within thirty (30) State workdays from the end of the report month, except; and

   c) Special quality assurance studies shall be delivered forty-five (45) State workdays after the date of request.

15.4.14 DELIVERABLES

The following deliverables to the Department are required:

1) Contractor Quality Assurance Standards and Procedures Manual to be updated quarterly and made available to employees in appropriate programs;

2) Monthly quality management reports, which address:

   d) Reviews of each monthly reported function;

   e) Other scheduled periodic system functions;

   f) Reviews of Contractor performance in meeting internal standards for accuracy and timeliness; and

   g) Updates of payment corrections;

3) Reports on the status of each payment tape and corrected/rescheduled payments;

4) Corrective Action Plans, Correction Notices, and all documentation for Problem Statements;

5) Monthly production reviews and reports of every employee involved in CD-MMIS operations;

6) Monthly Professional Review Productivity Reports of Dental Consultants and Clinical Screening Dentists by the QMDC;

7) Weekly QM report on claims aged over ninety (90) days and TARs aged over sixty (60) days;

8) Department-directed special quality assurance studies; and

9) Monthly QM performance report.

15.5 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Review and approval of the Quality Assurance Standards and Procedures Manual and quarterly updates;

2) Monitoring of the Contractor's operation;

3) Monitoring and review of the Contractor's QM program;

4) Independent auditing activities such as Medi-Cal dental QM Review;

5) Written notification to the Contractor in the form of Problem Statements of any errors found within CD-MMIS;

6) Assigning higher priorities to Problem Statements as deemed necessary;

7) Review and approval of all Problem Correction Tracking Reports, Corrective Action Plans, Correction Notices, and documentation updates submitted by the Contractor for all Problem Statements;

8) Review and approval of all Acceptance Testing deliverables and documentation;

9) For Acceptance Testing Unit,

   a) Monitor/review the Contractor's quality management program;

   b) Perform independent monitoring of the Contractor's Operation;

   c) Perform independent quality activities, such as Medi-Cal quality review;

   d) Notify Contractor via a PS whenever errors are identified within CD-MMIS;

   e) Set priorities for all PSs; and

   f) Review interim responses, review and approve CAPs and correction notices submitted by the Contractor for all PSs; and

g) Participate in the erroneous payment correction process (e.g., setting priorities, reviewing provider notification letters).

10) For Acceptance Systems testing:

a) Test operations activities by submitting test inputs, modifying test files, and reviewing system outputs;

b) Prepare comprehensive Acceptance Test cases and describe expected results. These test documents will be provided to the Contractor;

c) Review and approve test results prior to the Contractor promoting changes to production;

d) Attend Contractor walk-through to validate test case and test case results for accuracy and quality; and

e) Reserve the right to reduce the scope of Acceptance Testing if the Contractor can adequately demonstrate preparedness for CD-MMIS Operations, or expand levels of testing where the Department determines additional testing is needed.

16.0 SECURITY AND CONFIDENTIALITY

This Section describes the requirements for the Security and Confidentiality Plan, which shall be implemented by the Contractor by the contract effective date. The Contractor shall comply with the provisions of the contract's security and confidentiality requirements and the Contractor's provisions from the required implementation date through the end of this contract. If a subcontractor performs work, these requirements shall apply to that subcontractor. If the Contractor is initially using temporary facilities, an interim Security and Confidentiality Plan shall be submitted as a separate part of the Security and Confidentiality Plan; which clearly addresses how security and confidentiality requirements will be met in the temporary facilities.

The Contractor shall permit authorized Department, State and federal representatives to access any CD-MMIS facility, equipment, and related materials covered by this contract. Such access shall be at the discretion of the Contracting Officer as described in the Exhibit E, Additional Provisions, unless applicable law grants independent access to representatives of other State and federal agencies.

Other than the submittal of required deliverables, the Contractor shall provide any security and confidentiality procedures or related documentation to the Department within one (1) State workday after receipt of a request from the Contracting Officer or his/her designee. All procedures required in this section shall be developed and formally submitted to the Contracting Officer for review and written approval prior to implementation.

16.1 SECURITY AND CONFIDENTIALITY TRAINING PROGRAM

The Contractor shall:

1) Establish a security and confidentiality training program as part of the Security and Confidentiality Plan that is specifically designed for all levels of Contractor staff. All persons having responsibility for data processing equipment and/or the handling or processing of or the exposure to confidential data shall participate. Such training shall occur no later than two (2) weeks of the Department's approval of the training program. Once fully established and presented, an annual training program shall be maintained to ensure a continual awareness of security and confidentiality requirements. Additionally, new employees shall receive security and confidentiality training within one (1) week of their start date before they are given exposure to confidential data. Included in the above training shall be the fire and

safety training. The training shall cover a full range of security and confidentiality concerns including:

a) Definition of confidential data and examples of the various types, both hard copy and automated;

b) Federal and State law pertaining to confidential data;

c) Staffs' ongoing responsibility to ensure that unauthorized disclosure does not occur, with practical and realistic examples as to how such disclosure can occur and what actions will be taken by all staff to minimize or preclude the occurrence of unauthorized disclosure; and

d) Both manual and automated processes and the procedures that have been devised to protect these processes.

2) Ensure all employees having access to the Contracting Officers' network must attend the Department's, Information Security Training annually. Failure to complete such training will result in the employee being removed from the Contracting Officers' network until such requirements are met. Any employees found to be in violation of the policies set forth in this agreement, as well as the agreements set forth in the training course, will be removed from the Contracting Officer's network indefinitely. All changes in employee status (e.g., new hires, promotions, or separations) must be reported to the Contracting Officer immediately;

3) Submit annually, a report documenting employee attendance at Security and Confidentiality Training during the previous year. This report must include, at minimum:

a) Employee name;

b) Department employee works in;

c) Date of last training; and

d) Due date for next training.

The report must reflect if the employee is overdue for training and identify reasons for delays in training or non-attendance;

4) Ensure that the contents of this section are included in the standard language of any subcontract entered into to perform work arising from or related to this contract; and

5) Submit documentation acceptable to the Department to demonstrate compliance with security and confidentiality requirements and certification, in writing, that all requirements of this section have been, and will continue to be met, throughout the life of the contract.

16.2 SECURITY REQUIREMENTS

The Contractor shall:

1) Develop, implement, and maintain a Department approved Security and Confidentiality Plan that provides adequate physical and system security for the CD-MMIS and non-mainframe subsystems (IVR, STARS, DIMS) related to those portions of the CD-MMIS network not supported by the Health and Human Services Data Center (HHSDC). The Security and Confidentiality Plan shall address the requirements contained in this section and shall conform to the principles contained in the following documents:

   a) Federal Information Processing Standards (FIPS); and

   b) State Administrative Manual, Electronic Data Processing Data Security.

2) Address all Contractor facilities associated with this contract, whether temporary or permanent, shall be addressed in the Security and Confidentiality Plan and related procedures. Facilities shall include the computer room, software and data libraries, data preparation area, job entry and programming area, mail room/pickup areas, record retention sites, computer terminals (on/off-site), telephone room and any junction boxes between telephone room and computer room; and safe storage vaults (on/off-site). The Security and Confidentiality Plan shall also include transportation and data holding resources, both temporary and permanent, used by the Contractor throughout the term of the contract, and the facilities which handle both electronic and/or hard copy data;

3) Secure all Contractor facilities so that only authorized persons designated by the Contracting Officer, are permitted entry into the facility, and that such persons are restricted to those areas that they are permitted to access. Access control requirements shall include:

   a) Contractor staff shall be familiar with security policy;

b) Security guards shall be on-site at the Contractor's claim processing facility twenty-four (24) hours a day, seven (7) days a week. An up-to-date copy of the security policy must be maintained in the security station and its location and contents made aware to all security guards while on duty. The Contractor will provide the Department with a written certification that is signed by each security guard that he/she has reviewed the security policy, including all new material that has been updated or deleted. The Contractor will ensure that each security guard will review the security policy and sign a written certification on their first (1st) day of employment;

c) Facility entry and control points shall be guarded or locked at all times; locks shall be changed periodically. Control points shall be established for each of the following: main entrance to the data processing and claims processing facilities, service entrances, loading platform or garage entrances; inside entrance to the facility, and secondary entrances;

d) Closed-circuit TV shall monitor and record vulnerable areas (e.g., using surveillance cameras with video recording equipment), including but not limited to: the reception area; all outside entrances to the facility; inside entrances to the CD-MMIS area, if other Contractor accounts are served from the same location; loading docks and garages; computer facilities/room; and on/off-site vault storage areas. This closed-circuit TV and recording system shall link up to a monitoring station that is operative and staffed twenty-four (24) hours a day, seven (7) days a week. The recorded information for any twenty-four (24) hour period shall be logged and kept for a minimum of two weeks from the date recorded. The recorded information shall be available to the Department for viewing within twenty-four (24) hours of the request;

e) Ensure parking lots are well lighted and security guard escort service from the facility to the means of transportation shall be available, upon request, for both Contractor staff and Department staff working after daylight hours. Such escort service shall be available without endangering the integrity of the remaining security system;

f) Have available and furnish to the Department, on a monthly basis, a current list of all authorized staff and their levels of access. The Contractor shall ensure this list is also included in the Security and Confidentiality

Plan deliverable. Upon change of duty or termination of Contractor staff, access authority shall be updated or removed within one (1) day;

g) Require a badge and/or key card system for employees and visitors. The badge shall denote the level of access allowed to the individual and whether escort by Contractor or authorized Department staff is required. The key card, if used, shall be re-coded periodically, unless the Contractor proposes and the Contracting Officer accepts an equivalent system that will provide equal protection for the facility environment. The badge and/or key card system shall designate the Department office onto its own grid and not be part of the contracting officers central grid so as to allow for specific security controls and access;

h) Require a key card system for entrance to all Departmental staff designated areas. All entrance doors to the Department-designated areas shall have a key card system that does not require the use of the key card during normal business hours (as determined by the Department), but will restrict and/or record assess of staff entering after non-business hours. The Contractor shall develop a security access violation report and submit this report monthly to the Contracting Officer. The report must include, but not be limited to, badge number, name of employee assigned to the badge number, designated section or unit the employee is assigned to work, and the date, time, and location of the access violation;

i) Use the security guard(s) to inspect potentially suspicious items being brought into or taken from the facility;

j) Log the entry and exit of visitors and messengers by visitor name; agency represented; date and time of arrival and departure; and name of individual to whom visit is made. Identification and/or credentials of all visitors shall be checked. Visitors shall be given badges and escorted to their destination by the Contractor staff, Department employee, or security guard. A copy of the entry log shall be submitted to the Contracting Officer on a monthly basis to ensure that the accuracy and validity of the of the Security and Confidentiality Plan processes and procedures are contractually met;

k) Protect every CD-MMIS automated file by the Resource Access Control Facility (RACF)/Access

Control Facility/2 (ACF/2), or equivalent software, to prevent unauthorized access;

l) Require passwords to access CD-MMIS functions via computer terminal;

m) Staff a CD-MMIS Network Access Telephone Help Desk to assist Department-authorized on-line CD-MMIS users in resolving password/access inquiries. Upon contact from a Department user, in writing, the Contractor shall reset expired passwords or resolve other password problems without intervention of the Contracting Officer;

n) Develop and submit to the Department procedures for the handling, packaging, and transportation of sensitive/confidential data or resources. The Procedures shall ensure against unauthorized access;

o) Secure and lock the telephone room and any junction boxes between the telephone room and the computer room at all times with key control under the supervision of the building and/or data processing management. The Contracting Officer Telecommunications and network staff shall have access to all server rooms, phone rooms, and MPOE's as part of standard Network staff badge access as directed by the Contracting Officer;

p) Secure and lock the computer room/facilities at all times;

q) Protect the facility against intrusion during non-working hours with an appropriate surveillance alarm extended to the manned monitoring center; and

r) Establish and maintain internal security procedures and set safeguards in effect, which protect against possible collusion between Contractor employees and providers, as well as safeguard against other potential security breaches.

16.3 DISASTER PREVENTION

The Contractor shall:

1) Ensure computer room facilities be equipped with adequate measures and means to ensure prompt detection of any disaster as defined in the Glossary of Terms;

2) Maintain appropriate process for reporting disasters to appropriate authorities and the emergency handling of fire, water intrusion, explosion, or other disasters;

3) Ensure facilities be protected from physical disaster by the safeguards specified in this section;

4) Provide, as part of the Security and Confidentiality Plan, documentation that verifies how the Contractor will comply with these safeguards and which certifies that the requirements of this section have been met. The required safeguards are:

   a) Fire Prevention;

   b) Fire Detection; and

   c) Fire Suppression.

5) Ensure facilities shall comply with existing local, State, and federal fire safety regulations. Heat and smoke detectors and an automatic alarm system shall be maintained throughout the Contractor's facilities. A fire detection and alarm system along with automatic Halon or equivalent fire suppression systems shall protect all computer equipment, media storage, and environmental equipment areas. Areas where personnel are located or may be present, as well as supply rooms with forms and paper, shall be protected with an automatic fire detection and alarm system along with an automatic water sprinkler system except in rooms and/or areas where Halon or its equivalent are required. The Contractor facility shall have alarm link system(s) that is accessible to all personnel and that connect(s) to the local fire department or a security service that shall immediately notify the local fire department. Minimum fire resistance ratings shall be:

   a) Rooms housing computer equipment: one (1) hour;

   b) Tape and disk libraries: two (2) hours; and

   c) Vault areas (on-and off-site): four (4) hours.

6) Ensure the fire detection and alarm system power supply be uninterruptible with a twenty-four (24) hour battery pack;

7) Ensure all doors which are required to remain locked by this contract and that serve as points of egress in the event of emergency be equipped with “panic bar” door releases or, with the approval of the Contracting Officer, equivalent

mechanisms that comply with existing local, State, and federal fire safety regulations;

8) Ensure procedures dealing with fire safety, evacuation of the facilities and regular fire drills shall be developed by the Contractor and submitted to the Department for approval as a part of the Security and Confidentiality Plan deliverable(s). These procedures shall include planning for:

   a) Evacuation of disabled staff;

   b) Assignment and training of fire wardens for each Section who can be easily identified by employees;

   c) Designation of meeting places for staff after evacuation;

   d) Posting of exit signs and "evacuation route" maps throughout the facilities; and

   e) Clearing of personnel from all areas, including rest and lounge areas.

9) Conduct quarterly, unannounced fire drills to ensure the effectiveness of the fire safety instruction and procedures. The schedule for these drills will be provided to the Department at the beginning of each calendar year;

10) Train both Contractor and Department staff disaster prevention procedures. The Contractor shall maintain a list, and update monthly, those responsible for wardens and medical response teams; and

11) Provide monthly safety meeting with assigned staff to identify turnover and changes in policy and/or procedures. A Department representative must be present.

16.3.1 FLOOD AND EARTHQUAKE PROTECTION

The Contractor shall:

1) Ensure facilities be located at Department-approved sites that will be considered reasonably safe from flood and earthquake damage;

2) Install and maintain equipment to sense water intrusion and to warn appropriate staff of such intrusion, especially in areas housing electrical equipment or used for storage of microfilm, and/or any stored records; and

3) Ensure procedures discussing water intrusion, earthquakes, and the precautions and steps to be taken to prevent or to minimize the results of these eventualities in terms of danger to personnel, data, equipment, and facilities be developed and submitted to the Department for approval as a part of the Security and Confidentiality Plan.

16.3.2 FACILITY ENVIRONMENT

The Contractor shall:

1) Comply with existing state and local building codes. Facilities shall comply with equipment vendor requirements for temperature, humidity, and cleanliness. Any identified sources of potential computer equipment malfunction shall be eliminated;

2) Maintain an operational back-up power supply capable of supporting vital CD-MMIS functions, until power is restored in the event of power failure. This uninterrupted back-up power supply shall be immediately available to CPU and/or other equipment; which is sensitive to power surges or sustained power outages. An acceptable alternative will be a two (2)-feeder power hookup from a single electrical substation, with each feeder on a separate transformer; and with the requirement that, in the event of a power failure, an automatic four- (4) millisecond switch would switch from the primary to the alternate feeder; NS

3) Ensure that the operational back-up power supply is being regularly maintained and monthly tests will be conducted to ensure that the operational back-up power supply meets the back-up power supply specifications needed to support critical CD-MMIS functions.

16.3.3 THREATS

The Contractor shall:

1) To the maximum extent possible, safeguard the staff and facilities from danger stemming from bomb threats, terrorism, and civil disturbances; AND

2) Develop procedures dealing with these eventualities and shall submit such procedures to the Department as a part of the Security and Confidentiality Plan. All Contractor and Department staff shall have access to, and be familiar with

procedures addressing bomb threat, terrorism, labor disputes, and civil disturbances.

16.3.4 DISCLOSURE

1) Only authorized persons may access:

   a) Sensitive or confidential data, whether hard copy or electronic;

   b) Software programs and system documentation, including procedure manuals; and

   c) Computer room, disk and tape libraries, vaults.

2) The Security and Confidentiality Plan shall address procedures for dealing with the following four (4) potential categories of threats to sensitive data as well as items (a) through (c) above:

   a) Accidental disclosure, modification or destruction because of hardware error, software error, human error, or a combination of these; AND

   b) Casual access, resulting in unauthorized disclosure, modification or destruction by:

      i. Non-technical persons such as terminal operators, clerks, janitors/maintenance workers, or vendors/subcontractors;

      ii. Skilled technicians such as programmers, systems analysts, system software specialists, or others who have significant technical expertise;

      iii. Managers, supervisors, and others with authorized access;

      iv. Premeditated criminal acts;

      v. Natural disaster; and

      vi. Labor strikes.

3) Sensitive data shall be handled and stored in such a manner as to preclude unauthorized disclosure. It shall be stored in secured archives or, if destruction is necessary, it shall be shredded. The integrity of sensitive data shall be protected

from unauthorized disclosure at all times, including while in transit.

16.3.5 RISK ANALYSIS

The Contractor shall:

1) Perform and document a risk analysis, which defines all risks associated with collection, storage, processing, transition, transportation, discarding, or any other use of data under this contract. The Risk Analysis document shall contain timeframes for implementing the specified safeguards. The Contractor shall submit the risk analysis to the Department for approval;

2) Implement safeguards; which provide adequate protection against all risks identified in the risk analysis. For each identified threat or risk, the Contractor shall specify in the Risk Analysis document the following:

   a) An estimate of potential loss for each identified threat in terms of lost productivity, and the impact upon the Contractor's ability to meet contract requirements;

   b) An estimate of the probability of occurrence of each threat in a specified period of time; and

   c) The safeguards to be used to reduce the exposure to these threats to an acceptable level;

3) Ensure the Risk Analysis document be submitted as a separate section of the Security and Confidentiality Plan which can be removed from the major documentation in the initial submittal, subsequent drafts, and in the final, approved version;

4) In addition to the above, ensure all risk analysis backup documentation and safeguard review materials be delivered to the Department simultaneously with the Risk Analysis document. Annually, or as the Contractor or the Contracting Officer become aware of risks not addressed or addressed insufficiently, the Contractor shall perform additional risk analyses; review implemented safeguards; and modify, add, or delete safeguards as the need arises and as the Contracting Officer approves;

5) Ensure the Risk Analysis and safeguard implementation be completed before the start of Contractor CD-MMIS operations initially, and then annually before the end of each calendar year, unless the Contractor or the Contracting

Officer become aware of risks that have not been addressed or have been insufficiently addressed; AND

6) Perform a Risk Analysis and plan of correction on the identified issues and submit it to the Contracting Officer no later than ten (10) State workdays of identification of the risk.

16.3.6 BACKUP AND RECOVERY

The Contractor shall develop a Contingency Plan and Procedures, as a subset of the Security and Confidentiality Plan that provides for adequate backup and recovery for all Operations, both manual and automated, including all functions required to meet the back-up and recovery time frames. The Contingency Plan and Procedures shall include:

1) Back-up Requirements

The Contingency Plan and Procedures shall identify every resource that requires backup and to what extent backup is required. Backup needs (on and off-site) shall be included for:

a) Checkpoint/restart capabilities;

b) Retention and storage of backup files and software;

c) Hardware backup for the main processor;

d) Hardware backup for data entry equipment;

e) Network backup for telecommunications;

f) Data entry backup;

g) Data files plus file log (including location of files);

h) Application and operating system software libraries, including related documentation;

i) Personal computer applications developed outside of CD-MMIS; and

j) Procedure and user manuals.

Data entry back-up shall be volume tested and adjustments implemented, if necessary, to ensure that the data entry backup system has demonstrated the capability to handle the CD-MMIS data entry volume.

Off-site storage of back-up operating instructions, procedures, reference files, system documentation, and operational files, shall begin during the Takeover period. At least one (1) complete and continuously updated set of all material stored shall be maintained within twenty-five (25) miles of the Contractor's facility for easy retrieval. Procedures shall be specified for updating off-site materials;

2) Back-up Facility

In the event of a disaster or major hardware problem that renders the primary site inoperable, the Contractor shall allocate specific resources for an adequate and specifically identified back-up facility where CD-MMIS operations can be continued. The back-up facility and resources shall be sufficient to comply with requirements and deal successfully with both small and large disasters. Specific back-up facility(ies) and resources shall be designated to handle various types of potential disasters. The backup facility(ies) shall provide for:

a) Adequate hardware/software compatibility between the back-up facility and the CD-MMIS Operations facility;

b) Availability of adequate computer resources including computer time and all necessary peripherals for the entire CD-MMIS Operations;

c) Availability of adequate offsite data entry services, both key data and OCR;

d) Availability of alternate space for staff and equipment in the event that the main CD-MMIS facility cannot be used (e.g., it is destroyed, staff cannot occupy the building, labor dispute), and the availability of adequate staff to fully support CD-MMIS operations with no interruption to services;

e) Switching of CD-MMIS terminals to back-up facility;

f) Access to all resources mentioned in the Backup Requirements identified above;

g) Ability to shift operations to the backup facility within time frames and priorities which are acceptable to the Department; and

h) Method to periodically test the backup facility at least annually, to verify its ability to assume full CD-MMIS Operations.

After an initial test to be conducted prior to the Operations phase, the Contractor shall thereafter, make an annual test no later than June thirtieth (30th) of each State fiscal year, of the back-up facility's ability to assume full CD-MMIS Operations. At the Contracting Officer's discretion, Department staff may observe any and/or all backup and recovery tests. At the Contractor's expense, on an annual basis, a maximum of four (4) Department staff shall be allowed to inspect and observe any and/or all backup and recovery tests for facilities located out of California. Following completion of a back-up and recovery test, the Contractor shall submit a written report to the Contracting Officer, thoroughly describing the test, including, but not limited to:

a) The nature and extent of the disaster or problem that requires backup operation;

b) The people notified; AND

c) The steps taken to mitigate the effects of the problem (e.g., disaster) and to recover full CD-MMIS processing.

The back-up facility shall be available for transfer of the full CD-MMIS operation within twenty-four (24) hours after the main facilities are unable to perform all CD-MMIS operations. Mainstream claim payments shall be resumed within three (3) State workdays. Full time communication shall be restored with on-line terminals for file update and inquiry purposes within three (3) State workdays. Full CD-MMIS Operations shall be resumed within seven (7) calendar days.

The Contractor shall routinely, as part of its normal back-up procedure, provide the Department with any CD-MMIS materials requested by the Department, including CD-MMIS software and documentation; CD-MMIS manuals of all types; and CD-MMIS files;

3) Recovery

The Contingency Plan and Procedures shall provide for recovery from a minor malfunction to a major disaster or interruptions in work operations. Provision shall be made for the following:

a) Identification of staff to be contacted in the event of disaster. Assigned staff shall be thoroughly familiar with recovery procedures;

b) Contractor's demonstrated ability to recover from Department-defined disaster situations on at least an annual basis; If the recovery includes the use of a third (3rd) party, the contingency plan must include the method to assure the

availability of all necessary operations. The plan must include guarantees that in the event of a disaster, the Department will not be put in line for services from a third (3rd) party; AND

c) Inclusion of the Contingency Plan and Procedures shall be included with the Security and Confidentiality Plan.

16.3.7 CONFIDENTIALITY REQUIREMENTS

The Contractor shall

1) Develop, implement, and maintain a Security and Confidentiality Plan that prevents unauthorized disclosure of confidential data. The Plan shall be in accordance with:

   a) 45 Code of Federal Regulations, Section 205.50;

   b) California Public Records Act (California Government Code §6250 et seq.);

   c) Welfare and Institutions Code Sections 10850, 10850.1, 10850.2 and 14100.2;

   d) Title 22 California Code of Regulations Section 51009;

   e) California State Administrative Manual, Section 4800;

   f) Information Practices Act of 1977 (Civil Code §1798 et seq.);

   g) Confidentiality of Medical Information Act (California Civil Code §56 et seq.); and

   h) Health Insurance Portability and Accountability Act.

2) Ensure the Plan include, but is not limited to, detailed standards and procedures for the following items:

   a) Marking of sensitive data;

   b) Storing of sensitive data, including custodial responsibility;

   c) Access, retrieval, and duplication of sensitive data;

   d) Disclosure of sensitive data, including approving authority;

e) Disposal of inactive sensitive data, including secure archives and shredding;

f) Compilation of a list of all classes and types of CD-MMIS documents, data, and files; and

g) Confidentiality classification criteria for each item on the compiled list for items (a) though (f) as listed above.

3) Maintain a current inventory of all data. Inventoried data shall be classified either as "Public" (per Public Records Act, Government Code Section 6250 et seq.) or "Confidential" as defined in list (a) above. The Department shall respond to Contractor questions regarding the classification of data. The Contractor shall not disclose information classified as confidential without advance written authorization of the Contracting Officer; and

4) Except as provided in Records Retention Section, not disclose information classified as confidential without advance written authorization from the Contacting Officer or without formal, written release from the Medi-Cal dental provider or beneficiary involved.

Information, data, or programs of any type, as well as statistical or analytical material or reports based on material used by the Contractor that is not confidential under this paragraph, but are related to the administration of the Medi-Cal Dental Program and the Medi-Cal dental contract, shall not be disclosed by the Contractor to any person or entity without first obtaining the written authorization of the Contracting Officer.

16.4 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Review and approve, or disapprove, as appropriate, the Security and Confidentiality Plan and risk analysis document submitted by the Contractor;

2) Monitor implementation of the Security and Confidentiality Plan and any safeguards to be implemented as a result of the risk analysis document;

3) Perform periodic review of compliance with security and confidentiality requirements, including review of the risk analysis document; and

4) Meet federal requirements for CD-MMIS security and reporting.

17.0 RECORDS RETENTION REQUIREMENTS

The requirements for record retention differ depending on whether the records are (a) the Contractor's corporate or business financial records or (b) Medi-Cal Dental claims records. Rules governing the maintenance and disposition of corporate financial are contained in Exhibit D (F) and in Exhibit E, items fifty (50) to fifty-one (51) "Access to and Audit of Contract Financial Records". This section, Records Retention Requirements, governs the Contractor's responsibilities for claims payment records.

In general, the Contractor is assigned the responsibility for serving as the custodian of all claims payment records. The Contractor shall:

1) Maintain these records;

2) Produce copies of these records when required, or requested by the Department;

3) Provide authorized state and federal employees with access to records;

4) Retrieve records on request and certifying the authenticity of records retrieved;

5) Produce regularly scheduled reports on records requested;

6) Maintain and update a Records Retention Procedures Manual for use by Contractor and Department employees;

7) Purge, with prior Department approval, records that exceed required retention periods; and

8) Transfer claims payment records to the Department upon termination of this contact or to a subsequent Contractor, upon turnover of this contract.

17.1 OBJECTIVES

The objectives of the Records Retention requirements are to:

1) Establish that custodianship of claims payment records and all other documents processed by the Contractor (i.e. TARS, etc.) lies with the Contractor;

2) Assure that the Contractor maintains the ability to produce acceptable hard copies of claims payment records upon request;

3) Guarantee that authorized state and federal employees will have access to claims payment records when needed;

4) Assure that the Contractor will retrieve claims payment records upon request and in a timely manner;

5) Provide for a system of certifying the authenticity of claims payment records; and

6) Provide Contractor and Department employees with clear guidelines and instructions on procedures for executing the Contractor's record retention responsibilities.

17.2 ASSUMPTIONS AND CONSTRAINTS

In establishing these requirements, the Department makes the following assumptions and constraints:

For the purposes of this section, Claims Payment Records shall include:

1) Claims submitted to the Contractor for processing, regardless of medium (i.e. hardcopy and/or magnetic media);

2) Notices of Authorization (NOAs);

3) Appeals and appeals responses;

4) Explanation of Benefits (EOBs);

5) Copies of checks cashed by providers;

6) Claims Inquiry Forms (CIFs);

7) Resubmission Turnaround Documents (RTDs);

8) Treatment Authorization Requests (TARs);

9) Provider payment histories;

10) Provider correspondence;

11) Provider enrollment forms;

12) Provider Agreements;

13) Provider-initiated adjustments and any other transactions generated from an internal CIF;

14) Share-of-Cost records including MC 177 facsimiles;

15) Beneficiary payment histories;

16) Surveillance and Utilization Review case files;

17) Any other claims, forms, attachments, or reports, which are a part of, produced from, or generated as a result of the Contractor's claims processing activities;

18) All claims payment records, including but not limited to all the data and records transferred from the prior contractor and the Department. The database currently consists of all historical data back through 1974. Pursuant to the requirements and criteria in the Reference File Subsystem Section described in Exhibit A, Attachment II, Opertions, the Contractor may purge this data from the database to tape if approved by the Contracting Officer. The Contractor shall store and be able to retrieve this data;

19) These Records Retention requirements provide for maintenance, access, and retrieval of claims payment data for a period of ten (10) years from the date of their origin, and indefinitely for once-in-a-lifetime procedures (e.g., tooth extraction) and procedures needed for other history auditing. For other history, the Contractor shall store this data on appropriate long-term storage media in accordance with the requirements in the Exhibit A, Attachment II, Operations, Data Processing and Documentation Responsibilities section and be able to retrieve the data for Department, Federal, or Contractor usage;

20) For beneficiary payment histories, retrieval for the most recent seventy-two (72) months and once-in-a-lifetime procedures, and procedures needed for other history auditing, shall be made available by the CDR;

21) For provider payment histories, retrieval for the most recent thirty-six (36) months shall be made available by the CDR;

22) The Department may annually request a history search and/or hard copy reproductions of approximately one hundred thousand (100,000) claims payment records;

23) These Records Retention requirements are in addition to provisions elsewhere in this RFP, which require on-line request and retrieval of claims payment information (e.g., CDRs and/or documents); and

24) Claims/TARs/NOAs/CIFs/RTDs/MC-177s/etc. will be submitted by providers on Contractor-supplied forms,

computer tape, or by other electronic means approved by the Department.

17.3 CONTRACTOR RESPONSIBILITIES

The Contractor shall serve as the Custodian of Records of all claims payment records under the Contractor's possession and control.

The Contractor shall:

1) Preserve, protect, and maintain all claims payment records which are a part of, or result from, the Contractor's operations under this contract;

2) Preserve and protect all claims payment records transferred to it from the preceding contractor and the Department;

3) Maintain all claims payment records throughout the life of this contract unless otherwise approved by the Contracting Officer (see (g) below). Records, which have been involved in matters of litigation, shall be kept for a period of not less than three (3) years following the termination of such litigation regardless of the expiration or termination of this Contract;

4) Respond to all subpoena duces tecum served either on the Contractor or on the Department for documents in the possession of the Contractor;

5) Ensure that deadlines set by the Court for responding to subpoena duces tecum are met, and that when necessary, provide expert witness testimony regarding the named records within the Court's deadlines. This provision shall apply to claims that were adjudicated under a prior contract and that are in the Contractor' procession;

6) Notify the Department prior to, or concurrent with, responding to subpoena duces tecum, and/or providing expert witness testimony;

7) Dispose of records under its custodianship only after receipt of written approval from the Contracting Officer of the time, place, method of disposal, and specific records or group of records to be destroyed;

8) Preserve, protect, and maintain the original computer tape and electronic media (such as disk) containing claims submitted electronically for a minimum period of fifteen (15) days after their reproduction. The Contractor shall produce

computer facsimile copies of such claims as needed to meet all requirements under Exhibit A, Attachment, Operatiosn, Record Retention section;

9) Generate all Records Retention reports produced by CD-MMIS. Reports must meet requirements described in this section, and in Exhibit A, Attachment II, Operations, General Reporting Requirements section, unless otherwise specified by the Contracting Officer;

10) Develop and submit for prior approval by the Contracting Officer a brief summary describing all records and/or files maintained under this contract. The summary shall include the following:

a) The name of the file;

b) The media of retention (e.g., on-line, tape);

c) The duration (e.g., how long is it to be maintained);

d) Disposition (e.g., subsequent arrangements for retention or purge);

e) The method of access (the methodology necessary to gain access to the file);

f) The summary shall be sorted by production schedule (e.g., daily, weekly, monthly, quarterly, and/or annually); and

g) The summary shall be updated and produced on an annual basis. The first (1st) summary shall be delivered to the Department on the first (1st) day of the fourth (4th) month following assumption of the operations by the Contractor.

17.4 THIRD PARTY LIABILITY RECORDS

To assist the Department in exercising its responsibility for tort liability and estate recoveries, the Contractor shall meet the following requirements:

1) If the Department requests payment information or copies of invoices or paid claims for covered services to an individual beneficiary, the Contractor shall deliver the information to the requester within ten (10) State workdays of the request. Paid services shall be reported with a dollar value of the usual, customary, and reasonable charge made to the general public for similar services; and

2) The Contractor shall provide the Department with the name, address, and telephone number of Contractor staff responsible for receiving and complying with requests for service history information.

17.5 ACCEPTABILITY OF COPIES

Original claims payment records may be replaced with microfilm/microfiche. Other forms of Department-approved reproduced copies may be substituted at the discretion of the Contracting Officer during the life of the contract under the following conditions.

The Contractor shall:

1) Preserve, protect, and maintain original documents for a minimum period of sixty (60) State workdays after their reproduction unless required differently and in writing by the Contracting Officer. (NOTE: radiographs are returned to the providers immediately after adjudication and are not microfilmed, although in some cases a copy shall be made);

2) If claims or other documents are submitted on computer tapes or by other means approved by the Department, preserve, protect, and maintain the original computer tapes or other media (such as a disk) for a minimum period of sixty (60) State workdays after their reproduction. The Contractor shall produce computer facsimile copies of such claims/documents as needed to meet all requirements of this section;

3) Microfilm/microfiche copies of all claims payment records shall meet standards contained in the Exhibit A, Attachment II, Operations, Data Processing and Documentation Responsibilities section;

4) Ensure all reproductions from microfilm/microfiche and all other Department approved copies of claims payment records must be legible and clearly reflect all data including the provider's or provider representative's signature;

5) In reproducing facsimile claim copies of tape or other electronically submitted claims, ensure a copy of the accompanying transmittal document containing the original provider's or provider representative's signature shall be provided with each facsimile claim copy. If, however, the requested claim copies are in sequential order by Document Control Number (DCN), Most Recent Document Control Number (MRDCN), or Correspondence Reference Number

(CRN), and fall under a common transmittal document, one (1) copy of the transmittal document shall suffice providing there is no break in the sequential order of accompanying claim;

If the Department determines that hard copies produced from microfilm/microfiche versions of claims payment records are unacceptable in meeting the requirements of (4) and (5) above, the Department shall, at its discretion, extend the period for which original claims payment documents and records shall be maintained by the Contractor. Any additional costs incurred by the Contractor in connection with compliance with this provision shall be the sole responsibility of the Contractor; the Department shall provide no reimbursement to the Contractor for such additional storage costs.

17.6 ACCESS, RETRIEVAL AND CERTIFICATION

The Contractor shall:

1) Provide authorized access to retrieval services and certification of claims payment records under its custodianship during the life of this contract;

2) Establish and maintain procedures in keeping with the security provisions of this contract for allowing authorized state and federal employees, agents, or representatives' access to all claims payment records held under the custodianship of the Contractor. These access procedures shall be approved by the Department and subject to modifications by the Department;

3) Establish and maintain procedures for retrieving claims payment records requested by the Department. Such retrieval procedures shall be approved by the Department and subject to modifications by the Department. The Contractor retrieval procedures for claims payment records shall provide for the following:

   a) For requirements (b) and (c) listed below, maintain a minimum of six (6) years of records that shall be subject to the retrieval procedures as described in items (4) through (11) listed below, maintaining a minimum of ten (10) years of records that shall be subject to the retrieval procedures;

   b) Retrieving beneficiary histories by beneficiary identification number, beneficiary Social Security Number (SSN), or Medi-Cal Eligibility Data System

(MEDS) ID number or health access program identification number;

c) Retrieving provider histories shall be retrievable by provider number;

d) Retrieving claims/TARs/NOAs/CIFs and related documents shall be retrievable by document control number (DCN), most recent DCN (MRDCN), or correspondence reference number (CRN);

e) Retrieving EOBs shall be retrievable by warrant number;

f) Retrieving RTDs shall be retrievable by MRDCN;

g) Retrieving Share-of-Cost (MC-177) records shall be retrievable by DCN;

h) Retrieving correspondence to and from providers and beneficiary shall be retrievable by provider name and provider number, beneficiary name and beneficiary number, or the name of their authorized representative(s);

i) Retrieving provider enrollment documents shall be retrievable by provider name and provider number;

j) Retrieving provider agreements shall be retrievable by provider name and provider number;

k) Retrieving attachments to claims or other documents shall be retrievable by DCN, MRDCN, or CRN;

l) Maintain the location of all records under the Contractor's custodianship for the purposes of retrieval and accessibility, in a Master Index. This Master Index shall be updated monthly. The Master Index shall be made available to the Department upon request;

m) Delivering retrieved records to the requestor within ten (10) days from the date of receipt of the request by the Contractor, unless stipulated differently by the Contracting Officer or other sections of this contract;

n) Adhering to the following requirements, CDRs will meet the requirements for provider and beneficiary history retrieval. Beneficiary and provider history reports shall be run in accordance with the requirements of the Surveillance and Utilization Review Subsystem section,

and the Records Retention requirements of this section;

o) The Contractor shall provide the capability for all users to request copies of claims/TARs/CIFs/RTDs/EOBs via on-line request;

p) Unless otherwise specified in writing by the Department, a single copy of all requested document copies shall be provided in paper or compact disk format, depending on what is requested of the Department;

q) The requester identification number assigned to each user shall be the same number used to request CDRs;

r) Requests for which no documents are retrieved shall be accompanied with an explanation from the Contractor. At a minimum, the explanation provided shall include, but not be limited to:

i. Document not on file; and

ii. Invalid document number.

s) All records prepared or compiled on continuous pin-fed computer paper for delivery to a requester shall be burst by page and comply with the requirements in Exhibit A, Attachment II, Operations, General Reporting Requirements section, or to the requester's specifications, prior to delivery to the requester;

t) Access and retrieval procedures shall include all access to third (3rd) party liability interface programs developed under the CD-MMIS or accessible through CD-MMIS;

u) Document copies shall be delivered to local users and/or mailed to users located beyond the twenty-five (25)-miles-of-the-capital limit no later than twenty-four (24) hours following the date/time the request is received by the Contractor. This standard shall apply to the first (1st) two hundred (200) documents requested on any one day. The Contractor must respond to all documents requested above the two hundred (200)-documents-per-day standard within forty-eight (48) hours of receipt of the request;

v) Produce an automated report of all requests for record retrieval and provide it to the Department on a daily basis;

w) Deliver to the Department by the fifth (5th) State workday of each month a monthly Document Retrieval Performance Report;

x) Establish, maintain, and update as necessary procedures for certifying the accuracy and authenticity of original claims payment documents, microfilm copies of claims payment documents, and hard copies produced from microfilm/microfiche versions of claims payment records. The Contractor shall be required to certify that hard copies of microfilm/microfiche records received from the prior contractor are in fact copies of records transferred from the prior contractor to the current one. Certification procedures shall be subject to Department review, written approval, and modification, and these procedures shall be included as a separate section or chapter of the Records Retention Procedures Manual;

y) In addition to the responsibilities contained in this section, provide all necessary assistance to the Department in the identification, retrieval, and certification of claims payment records and any other requested information for the purposes of the investigation, prosecution, or defense of Medi-Cal Dental related cases. Such cases may include, but not be limited to: fraud prosecutions, provider appeals, third (3rd) party liability recovery efforts, overpayment recovery efforts, Department recovery efforts, and actions against the Department. The Department shall have the authority to review, approve in writing, and modify the procedures, steps, or other services by which the Contractor attempts to comply with this requirement;

z) Be responsible for replying to all other parties' requests for claims payment records other than the Department when such requests have been submitted to the Contractor in the form of a subpoena duces tecum. The Contractor shall perform this service as part of its custodianship responsibilities. The Department shall provide no additional reimbursement to the Contractor for the provision of this service. The Contractor may request payment for such services from the court or the party issuing the subpoena; and

aa) Maintain accurate records of all document/record retrieval requests in accordance with this subsection and the Security and Confidentiality Section.

17.7 AUTOMATED DOCUMENT RETRIEVAL SYSTEM

Through the Automated Document Retrieval System (ADR), the Department and the Contractor have the ability to retrieve copies of records and documents (other than CDRs) in a timely manner through on-line requests, and track the number, accuracy, and dissemination of each request. The description of the system and procedures for end-users shall be included in the Records Retention Procedures Manual.

Contractor completion and delivery of requested copies shall meet the Access, Retrieval, and Certification requirements and in addition:

1) When the priority indicator is checked, the request shall be processed prior to a request that does not have the indicator checked; and

2) All requests without the priority indicator shall be processed in the date/time order received.

17.7.1 REPORTING REQUIREMENTS

1) Document Retrieval Request Summary Report

   The Contractor shall:

   a) Produce a report in the form of a hard copy print-out of each document request made through ADR. These reports shall be used by the Contractor to retrieve requested document copies, and shall become transmittal sheets for routing these copies to the requester. The transmittal sheets shall be produced and delivered to the Department on a daily basis, attached to the requested copies. A duplicate of each transmittal sheet, signed/initialed and dated by the requester to indicate receipt, shall be retained by the Contractor for inclusion of data in monthly Document Retrieval Performance Reports (see below). After transmittal data is compiled in the monthly report, the duplicate transmittal sheet shall be disposed of by the Contractor in accordance with the Exhibit A, Attachment II, Operations, Security and Confidentiality Section.

   b) The daily report(s) shall include, at a minimum, the following information:

      i. Requester name, number, and address;

ii. Date of request;

iii. DCN, MRDCN, and/or CRN of the requested document;

iv. Payment date;

v. Check number;

vi. Provider number;

vii. Beneficiary Social Security Number;

viii. Beneficiary Identification Number;

ix. Number of copies requested;

x. Total number of copies;

xi. Request filled by;

xii. Date request completed;

xiii. Date request mailed/delivered;

xiv. Requester Comments/Initials Block; and

xv. Date request received by requester;

c) The sort sequence for the reports shall be:

i. First (1st) Sort Key: By Requester Name/Requester Number;

ii. Second (2nd) Sort Key: By Date of Request; and

iii. Third (3rd) Sort Key: By DCN, MRDCN, and/or CRN

2) Document Retrieval Performance Report

The Contractor shall produce, and deliver to the Department by the fifth (5th) State workday of each month, a Document Retrieval Performance Report.

a) The monthly performance report shall include at a minimum, by requester number, the following information for total unduplicated requests for each type of document requested:

i. Total number of copies requested;

ii. Total number of copies delivered;

iii. Total number of copies delivered late;

iv. Total number of copies not delivered;

v. Number of requests received by the Contractor under the twenty-four (24) hour standard;

vi. Number of requests received under the twenty-four (24)-hour standard that was delivered within twenty-four (24) hours;

vii. Number of twenty-four (24)-hour standard requests delivered late;

viii. Number of twenty-four (24)-hour standard requests not delivered;

ix. Number of requests received by the Contractor under the forty-eight (48)-hour standard;

x. Number of requests received under the forty-eight (48)-hour standard that was delivered within forty-eight (48) hours;

xi. Number of forty-eight (48)-hour requests delivered late;

xii. Number of forty-eight (48)-hour requests not delivered;

xiii. Number of priority requests received;

xiv. Number of priority requests delivered;

xv. Number of priority requests delivered late;

xvi. Number of priority requests not delivered; and

xvii. Number of undelivered requests and the reasons the requests were undelivered.

b) The monthly performance report shall summarize, by requester number and total, the above information for those documents requested during a month. For those documents that are late in delivery or are not delivered, the report shall list the type of document (i.e., claims, etc.), the document number(s) (e.g., the number or

name by which the document was retrieved) of each requested document, the number of days late in delivery, and shall give the reason for delay or non-delivery; and

c) For those documents not delivered, the report shall show the number of days outstanding beyond the delivery date for each requested document number. Documents not delivered during the report period shall be listed on each subsequent monthly report until such documents are delivered. Summary data shall be included for each of the categories. This report shall be attached to each monthly payment invoice submitted by the Contractor to the Department and shall meet the retrieval standards set by the Contracting Officer. The monthly performance report may be modified at the discretion of the Contracting Officer.

3) Records/Files Summary

The Contractor shall develop and deliver to the Department a Records/Files Summary, including a brief description of all records and/or files maintained under this contract. The summary, at the minimum, shall include the following:

a) The name of the file;

b) The medium of retention (on-line, tape, etc.);

c) Duration (how long the file is maintained in the defined media);

d) Disposition (subsequent arrangements for retention or purge);

e) Access (the methodology necessary to gain access to the file); and

f) The summary shall be sorted by production schedule daily, weekly, monthly, quarterly, and/or annually. Upon approval of the Contracting Officer, the summary shall be updated and produced on a quarterly basis.

17.8 RECORDS RETENTION PROCEDURES MANUAL

The Contractor shall:

1) Prepare, update, and maintain a Records Retention Procedures Manual, which thoroughly describes the specific

steps to be followed in order to execute the Contractor's record retention responsibilities. This procedure manual shall be prepared and approved by the Department for the use of both Contractor and Department staff, and shall be submitted for Department review and approval during Takeover; and

2) Maintain and update the procedure manual, but in no case less than annually, to accurately reflect any changes in the Contractor's record retention procedures. Copies of all procedure or manual amendments shall be delivered to the Contracting Officer for review and written approval prior to publication and distribution.

17.9 TRANSFER ON TERMINATION

The Contractor shall upon termination of this contract, transfer control of all claims payment records under its custodianship to a successor contractor or the Department. The Department shall retain the authority to designate the manner and method by which claims payment records shall be transferred. The Department shall also designate the party to whom the records shall be transferred. In addition, copies of checks issued by the Contractor under this contract shall be available to the successor contractor for research purposes. The Department may exempt from transfer those records retained by the Contractor for litigation purposes.

17.10 DELIVERABLES

In addition to responding to any Department or Department-approved requests for copies of claims records, the Contractor shall:

1) Submit a Records Retention Procedures Manual five (5) months after the contract effective date and update annually and in addition as necessary, with prior Department approval;

2) Establish and maintain an initial Records/File Summary eight (8) months after the contract effective date, and update quarterly;

3) Establish and maintain a Master Index eleven (11) months after the contract effective date and update monthly;

4) Produce hard copy report of on-line document request through the ADR system, and deliver with requested copies (Document Retrieval Request Summary Report);

5) Compile on-line document requests into a monthly Records Retrieval Performance Report;

6) Preserve, protect and maintain original claim media for a period of at least sixty (60) State workdays after reproduction; and

7) Respond to and notify the Department of any Subpoena Duces Tecum.

17.11 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Identify all records from prior contractors that will be subject to these records retention responsibilities;

2) Review and approve in writing, prior to implementation, any method and manner the Contractor proposes to purge, destroy, or otherwise dispose of claims payment records; and

3) Review and approve in writing the Contractor's records retention procedures, reports, and updates, including but not limited to the Master Index, Records/Files Summary, Document Retrieval Request Summary Report, and Records Retention Procedures Manual.

18.0 EXPERT WITNESS REQUIREMENTS

This section describes the requirements governing the manner in which the Contractor shall provide court-experienced expert witness services for the Department and for agents of its political subdivisions (such as County District Attorneys). It also provides for the delivery of court-experienced expert witness services in those instances in which the Department has no direct involvement or interests. This section further describes the Contractor's obligation to appear in court, respond to subpoenas and/or subpoenas duces tecum, and provide testimony in dental related administrative hearings.

18.1 OBJECTIVE

To provide court-experienced expert witness services for the Department and its political subdivisions at dental related administrative hearings, proceedings, or other meetings or events on all aspects of the Contractor's operations under this contract in order to assist in the reduction of Medi-Cal dental program costs. On behalf of the Defendant, provide accurate responses to subpoenas and subpoenas duces tecum by the stipulated time requirement(s), in manners of requests for information dealing with the administration of the Medi-Cal dental program.

18.2 ASSUMPTIONS AND CONSTRAINTS

1) The Department and its political subdivisions will have a need to provide courts, administrative law judges, hearing officers, attorneys, or other authorized persons with accurate descriptions of the manner in which claims are processed, adjudicated, and paid. The Department will rely on the Contractor to be prepared to provide all pertinent testimony, including testimony that may be required in taking action to recover improperly paid Medi-Cal funds;

2) The Department and its political subdivisions will make approximately two hundred (200) requests annually for expert witness services in the various kinds of actions, including actions in small claims court and responses to subpoenas and/or subpoenas duces tecum;

3) As part of its responsibility for underwriting the Medi-Cal dental program, the Contractor shall provide written analysis and expert witness services in dental related administrative hearings and in court regarding the actions the Contractor has taken in exercising its responsibilities; and

4) There may be demand for expert witness services in regard to actions by, or on behalf of, third (3rd) parties, to which the Department is not a party (e.g., two (2) providers engaged in a lawsuit against one another).

18.3 CONTRACTOR RESPONSIBILITIES

1) At the request of the Department or any of its political subdivisions, and with the Contracting Officer's prior approval, provide court-experienced expert witness services at locations within California for hearings, proceedings, or other meetings or events dealing with legal matters in the administration of the contract;

2) At the request of the Contracting Officer, shall provide expert witness services in matters dealing with certification of copies of information (e.g. Claim Detail Reports, Provider Enrollment application information, etc);

3) Provide written analysis, supporting documents, and expert witness services in hearings and in court, including small claims court, regarding the actions the Contractor has taken in exercising its responsibilities under this contract;

4) Ensure the qualifications of the individual(s) designated to provide expert witness service should include possession of a bachelor's degree in business administration, or a bachelor's degree in a related field, or the equivalent in comparable experience; an additional three (3) years experience in professional/technical procedures for system operation; and excellent verbal and written communication skills. The designated expert witness staff shall be properly trained by the Contractor to perform this function and shall be thoroughly familiar with all aspects of operations under this contract;

5) In addition to the designated expert witness in item 4 above, provide a Dental Consultant (licensed by the Dental Board of California) for expert witness services in matters dealing with the delivery of dental care;

6) During takeover, and annually thereafter, designate and identify staff persons available to perform the expert witness function so as to meet all requirements and time limitations under this section, including time limits set by any subpoena or subpoena duces tecum served on the Contractor or the Department. The Contractor shall determine if any subpoenas or subpoenas duces tecum served are appropriate to the administration of the Medi-Cal dental program. The Contractor will respond to the subpoenas and

subpoenas duces tecum with appropriate references to the Evidence Code and/or Code of Civil Procedure;

7) Provide specific additional or substitute employees, other than the designated court-experienced expert witness staff, to provide testimony or information about the Contractor's operations under this contract at the option of the Department. This option shall be extended to political subdivisions of the Department only upon written permission from the Contracting Officer. The designated court-experienced expert witness shall be properly trained by the Contractor to perform this function and shall be thoroughly familiar with all aspects of operations under this contract;

8) Make an expert witness available to provide testimony at hearings, proceedings, or other events in which the Department has no direct involvement or interest. The Contractor shall receive written approval from the Contracting Officer prior to the delivery of expert witness services as defined in this paragraph. The Department shall not provide any additional reimbursement to the Contractor for the provision of such services. The Contractor may receive payment for these services from the court or other parties requesting the appearance of an expert witness;

9) Provide written notification to the Department prior to the delivery of all expert witness services, and/or response(s) to subpoenas or subpoenas duces tecum. The notice shall be no later than twenty-four (24) hours after the Contractor is aware of the request, notification, subpoena or subpoena duces tecum. The response to any subpoenas and/or subpoenas duces tecum shall clearly define the relationship between the Contractor and the Contracting Officer;

10) Notify the Department in writing of any third (3rd)-party action or other proceeding (described in paragraph (h) above) in which it will provide expert witness services. The notice will briefly summarize the nature of the case and the issues on which expert testimony will be given. The notice will be given to the Contracting Officer within twenty-four (24) hours after the date on which the Contractor is notified that an expert witness will be required; and

11) Not release any confidential information in response to a subpoena or subpoena duces tecum without prior written authorization from the Contracting Officer.

18.4 COURT OBLIGATIONS AND ADMINISTRATIVE HEARINGS

When the Contractor is named as a party in any civil court case (e.g., small claims court case) related to claims payments, the Contractor shall:

1) Appear in court to defend against actions related to payment of claims under this contract. In cases that raise or include issues relating to the administration of Department policy, the Contractor shall promptly notify the Contracting Officer that such a case has been served. The notice shall be in writing to include a copy of the plaintiff's claim and submitted delivered to the Contracting Officer within one (1) State workday. If there is insufficient time prior to the hearing for representatives of the Department to prepare and appear, the Contractor shall appear and defend the case until such time as the defense of the case can be tendered to the Department;

2) Not initiate legal actions related to payment of claims or any other legal activity under this contract without prior written authorization from the Contracting Officer;

3) Notify the Department prior to the Contractor's appearance in civil court cases, and prior to the Contractor's response(s) to any court subpoenas or subpoenas duces tecum. These notifications to the Department shall occur no later than (beginning with the receipt of notification) twenty-four (24) hours after the Contractor has notice of the subpoena, subpoenas duces tecum, or otherwise receives a need to appear; and

4) At the request of the Department, provide testimony at a dental administrative hearing or court proceeding, if deemed necessary by the Contracting Officer.

18.5 COST STIPULATIONS

1) The cost of the court-experienced expert witness service and/or the cost of initiating or defending court actions shall be in the Contractor’s fixed price operations bid. There shall be no other payment by the Department for the provision of these services;

2) The Contractor is required to indemnify the Department for the cost of claims, which the Contractor does not choose to defend against an action, which results in an award, by default being made against the Department. In that case, the amount of the award shall be paid according to the judgment directed by the Court, and shall not come from the Pure Premium Fund and shall not be subject to the calculation of the gain/loss of that Fund; and

3) In any dental related administrative fair hearing where the Contractor has met the obligation to provide court-experienced expert witness services or has been excused by the Contractor Officer from the obligation to provide these services, and there is an award in favor of the beneficiary, the Contracting Officer shall, upon the request of the Contractor, make a ruling on the scope of benefits (as defined by Title 22, California Code of Regulations, Section 51307 – Dental Services), of the services awarded. If the Contracting Officer determines the service is beyond the scope of the benefits of the Medi-Cal dental program, the Department will reimburse the Contractor the actual cost of these services when the Contractor pays for the service.

18.6 DEPARTMENT RESPONSIBILITIES

1) The Contractor's designee as court-experienced expert witness is subject to prior approval by the Department. The Department will notify the Contractor in a timely manner should a court-experienced witness other than the Contractor’s designee be required;

2) The Department will notify the Contractor as soon as possible of the date, time, and location of dental related hearings, legal proceedings, or other meetings or events at which specific expert witness services are to be provided; and

3) The Department will notify the Contractor in a timely manner of the nature of the subject matter to be covered and the type of testimony to be presented.

19.0 STAFF TRAINING REQUIREMENTS

The Contractor shall provide for a comprehensive training and personnel development program for all Contractor personnel involved in and performing Contractor responsibilities as specified, and to provide comprehensive training to Department staff designated and authorized in this contract by the Contracting Officer. The Contractor shall also provide training for Takeover, as specified in Exhibit A, Attachment I.

19.1 OBJECTIVES

1) To provide training to Contractor staff regarding program regulations, procedures, and operations, including new procedures and operations brought about by change instruments, and all policies related to the claims processing system, to assure effective and efficient adjudication of claims, TARs and related documents;

2) To provide training to Department staff on the claim and TAR processing operation, and to promote a comprehensive understanding of program procedures and policies related to the claims processing system to facilitate effective and efficient utilization by Department users of the system; and

3) To ensure quality performance and competence in the execution of the Contractor responsibilities by those responsible for ongoing operations.

19.2 CONTRACTOR RESPONSIBILITIES

The Contractor shall:

1) In addition to training requirements specified in the Exihibit A, Attachment II, Operations, Operations Requirements Section, provide a comprehensive training and personnel development program to all Contractor personnel involved in and performing Contractor responsibilities as specified herein.;

2) Provide training that is specifically designed to ensure Contractor staff can adequately accomplish all Contractor responsibilities. In addition, training shall encompass sessions as required to cover new or modified policies, new program regulations, new equipment, and new system procedures that occur as a result of changes to the system through the Change Order/DOIL process. This training shall include new technology, such as web page design, that may be used to perform Contractor responsibilities, and shall

provide Contractor staff with the skill levels that ensure full preparedness for the performance of all Contractor responsibilities. The training is to further ensure a reduction in errors as identified by the Department or Contractor quality control reviews as well as to guard against problems identified through the Problem Correction System;

3) Provide, at a minimum, training sessions on a quarterly basis for Department staff, with a minimum attendance of five (5) Department staff. The quarterly training sessions shall include Department on-line access for use of the system and its software as stated in Data Processing and Documentation Responsibilities Section. Training shall include ongoing courses for Department staff and orientation training for new staff regarding the claim processing operation. The ongoing training shall be oriented to Department staff skill level, while orientation training shall be oriented to new Department staff, recently assigned to their duties;

4) Ensure authorized federal representatives have access to all training sessions upon Department notification to the Contractor of the intent of federal representatives to participate in or attend a Contractor training session;

5) Ensure training sessions for Department staff and Contractor staff are conducted in the Sacramento area. The Contractor shall conduct training sessions for Department staff in other locations throughout the State as specified by the Contracting Officer;

6) Develop materials, design courses, and supply resources necessary to train Department staff and other individuals approved by the Contracting Officer, on the functional operation of all aspects of the Contractor responsibilities, including tours of the Contractor facilities, and explanations and walk-through of system operations. Tours of the facility shall be made available to Department staff and other individuals approved by the Contracting Officer, upon request by the Contracting Officer;

7) Include major areas to be covered in the Contractor's training for Contractor and Department staff, but not limited to:

   a) Administrative Support Services;

   b) Claims/TAR/CIF/NOA processing;

   c) Para-professional and Professional Review;

d) Clinical Screening;

e) Quality Management;

f) DIMS training;

g) Data Entry, including computer media, OCR, and KDE;

h) Provider Relations and Appeals;

i) Use of the on-line data element dictionary, including hands-on training at terminals;

j) Telephone Service Center Operations (Provider and Beneficiary);

k) S/URS and CDR training;

l) Dental Outreach activities;

m) Security and Confidentiality procedures;

n) Beneficiary Services;

o) Dental Fair Hearings;

p) Specialized Claims Processing (i.e., TMJ. etc.);

q) Mailroom and Prescreening;

r) Checkwrite and Payment;

s) Share of Cost (MC-177);

t) Computer and Ancillary Equipment;

u) STARS training;

v) MMIS System Files, Programs, and Reports; and

w) Each of the CD-MMIS subsystems plus all other dental programs claims processing (e.g., CHDP, CHDP Gateway, CTP, CCS, GHPP, and Healthy Families).

8) Ensure training includes tours of the Contractor's facilities, and explanations and walk-throughs of systems operations, as appropriate and within the context of classroom sessions. Tours of the facilities shall be made available to State and/or federal staff upon request from the Contracting Officer.

9) Make appropriate changes and/or modifications as deemed necessary by the Contracting Officer within ten (10) State workdays in cases where the Department disapproves the Contractor's training recommendations (e.g., staff trainers, training courses, course content, method of presentation, training plans, training manuals, updates, and status reports);

10) Provide special training sessions for Department staff in addition to those required elsewhere in this contract, at locations throughout the State as designated by the Contracting Officer. These will be limited to a maximum of twenty (20) one-day sessions for the life of the contract. The training shall be conducted by existing staff and shall be provided at the request of the Contracting Officer. This training shall be a part of the Contractor's fixed price bid, except that the cost for rental charges incurred for the provision of adequate meeting space and travel/per diem for the trainer shall be paid on a cost reimbursement basis if these costs are incurred by the Contractor as specified in Exhibit B, Payment Provisions section.

11) In its fixed price bid, provide training sessions for technical and non-technical, Contractor and Department staff, carry out the changes in implementation and day-to-day operation of the system brought about as a result of changes made to the contract through the Change Order process. The training budget shall include, as part of the fixed price, the cost for providing training to the involved staff as a result of approximately twenty (20) Change Orders. To project the cost of the Change Order training sessions, the Contractor shall assume one thousand four hundred (1400) hours of training per year. Consideration must be given to the fact that these changes involve training Contractor operations staff throughout the Contractor's operations including, but not limited to, Quality Management and Systems Group staff, provider relations, claims review and entry, suspense, appeals. Changes can vary significantly and there can be approximately four (4) staff hours for each of the staff members plus the associated training materials for each Change Order;

12) Ensure all training sessions be conducted in a classroom setting with appropriate equipment and materials for each participant to engage fully in the training process. All training sessions shall have informational materials and, at a minimum, pre-test and post-test evaluation. Training sessions shall not be scheduled as an optional program during State or Contractor employees' off-duty hours;

13) When individual or work group performance problems are identified through quality management review, Problem Statements, or other methods, identify the cause of the procedural error(s) and take immediate steps to correct staff performance through necessary training. Quality Management staff involved in the identification of the performance problem(s) will be available to advise and assist in the design and implementation of the remedial training plan; and

14) Ensure Contractor staff training shall be organized and scheduled so as to minimize the impact the absence of the participants may have on their workload, their work unit(s) or the operations schedule.

19.2.1 TRAINING PLAN

The Contractor shall:

1) Develop and update annually, the staff training plan as described below, which will include orientation, continuing education, and on-going operations training. The training plan is subject to approval by the Department. Other personnel, in addition to Department personnel, are those employees who are designated by the Contracting officer to attend training; and

2) Schedule and execute the training plan to ensure full preparedness for execution and performance of all Contractor responsibilities specified in the Takeover and Operations Sections. The training plan shall include at a minimum:

   a) Number and type of Contractor staff to be trained;

   b) Number and type of Department staff to be trained;

   c) Training content and subject areas;

   d) Training objectives;

   e) Training methodology and presentation modes;

   f) Techniques to measure learning as a result of training (e.g., evaluation techniques);

   g) Description of how student evaluations will be used to improve course content and presentations;

   h) Pre-Test and Post-Test criteria;

i) Expected operational inputs as a result from training;

j) Description of the professional background, skills, training experience, and knowledge of subject matter of proposed trainers;

k) Schedule of initial training for new employees including required curriculum designated by work unit or classification and duration of initial training periods;

l) Monthly training hours to be provided for both Contractor staff and Department staff;

m) Total annual hours devoted to training activities; and

n) Description of tools and techniques to be used on an ongoing basis to design and upgrade programs that better serve the intended program purpose and meet the needs of the trainees.

19.2.2 TRAINING MANUALS

The Contractor shall develop training manuals derived from the user manuals for procedures described in Data Processing and Documentation Responsibilities Section. The training manuals shall be generated from the most current materials available and shall be used when selecting item(s) for use in the training course(s)/class(es) and shall be in a location that is easily accessible and available to Contractor staff at all times. Training manuals shall be kept up to date with corresponding changes and revisions.

19.2.3 ANNUAL TRAINING PLAN UPDATE

1) On a yearly basis, the Contractor shall update the training plan to address all training programs scheduled. The Contractor shall submit the yearly update to the Department for approval, with written notification of any changes or modifications to the training plan, within thirty (30) calendar days of the first (1st) day of the calendar year after the contract effective date;

2) The plan updates shall include a report which summarizes at a minimum the following performance indicators:

   a) Number of Contractor staff trained during the previous year;

b) Number of Department staff trained during the previous year;

c) Job classification(s) of staff participating in training;

d) Training subject(s);

e) Training objective(s);

f) Training methodology;

g) Evaluation techniques;

h) Description of how trainee evaluations will be used to improve/alter course content and presentations;

i) Pre-Test and Post-Test results;

j) Total number of hours for training both Contractor staff and Department staff;

k) Sample copies of material(s) used in training sessions; and

l) Description of tools/techniques to be used on an ongoing basis to design and upgrade dynamic training programs that better serve the intended purpose and meet the needs of the participants.

19.2.4 STAFF TRAINING (QUALIFICATIONS)

The Contractor shall:

1) Provide adequate staff to develop (including subject matter primary users and/or experts), facilitate, train, and monitor the required training program activities. In addition, the Contractor shall provide coordination for scheduling and registering both Department staff and Contractor staff for participation in the training sessions. The coordination will be in liaison with designated Department staff assigned to monitor the activity;

2) Include in the training plan, and in all updates to the training plan, the professional classification, qualifications, and responsibilities of the proposed trainer(s). The qualifications of the person(s) conducting the training shall reflect his/her competence and ability to give instruction in the required areas. This shall include knowledge and experience in the areas covered and the ability to impart that knowledge to

others. All trainers shall have, at a minimum, two (2) years demonstrated and documented experience or knowledge in their training and subject area; and

3) Ensure that experts in the subject matter field are involved in developing class materials for the courses being presented. Expertise will be determined by the Contractor based on a combination of education and practical experience. In addition, the subject matter experts shall be active participants in regularly auditing the courses to ensure that trainers are knowledgeable, and effective in training others in the subject matter being presented. The updates to the training plan shall describe how this activity will be completed on an ongoing basis.

19.2.5 PROFESSIONAL REVIEW TRAINING

The Contractor shall develop and implement a training plan designed to ensure the highest level of professional review skill for each Dental Consultant and Clinical Screening Dentist. Training for these consultants and dentists shall begin prior to the start of TAR processing during Takeover.

The Quality Management Dental Consultant (QMDC) has the overall responsibility for all Dental Consultant and Clinical Screening Dentist training and the monitoring of professional review and adjudication skill. The qualifications and responsibilities of the QMDC are described in Exhibit A, Attachment II, Operations, Quality Management Section.

The QMDC shall request the advice, review, and participation of the Department Dental Program Consultants in the development of training.

19.2.6 DENTAL CONSULTANT TRAINING PLAN

The Dental Consultant training plan shall be included in the Contractor's Training Plan. The Contractor's responsibilities for training Dental Consultants shall be the same as those required for all training. In addition, Dental Consultant training shall provide for:

1) Comprehensive training and adjudication skill review for all newly hired Dental Consultants prior to their assumption of final adjudication authority; and

2) Refresher training to be held a minimum of every six (6) months.

19.2.7 CLINICAL SCREENING DENTIST TRAINING PLAN

The Contractor shall develop and maintain a training plan for Clinical Screening Dentists that will ensure their ability to meet the requirements pertaining to clinical screening as described in Exhibit A, Attachment II, Operations, Beneficiary Services Section. The Clinical Screening Dentist training plan shall be included in the Contractor's Training Plan.

19.2.8 SYSTEMS GROUP (SG) TRAINING PLAN

The Contractor shall develop and maintain a training plan to ensure SG staff meet the System Development requirements as described in Exhibit A, Attachment III, Change Requirements. Fifty-percent (50%) of the training shall consist of information technology related courses (i.e., database management, systems analysis).

19.3 REPORTING REQUIREMENTS

The Contractor shall:

1) Submit to the Department a quarterly status report on the progress and status of the actual training and annual Training Plan updates. The report shall be delivered to the Department within five (5) State Workdays after the last workday of the quarter. The quarterly report shall include, at a minimum, the following:

    a) The number of Contractor staff registered for training;

    b) The number of Contractor staff who actually attended the training;

    c) The number of Department staff registered for training;

    d) The number of Department staff who actually attended the training;

    e) Narrative summary of changes, progress, and/or problems in the training programs; and

    f) Narrative summary of all class participants' evaluation responses regarding the effectiveness of the training.

19.4 DEPARTMENT RESPONSIBILITIES

The Department shall:

1) Designate State staff who shall participate in Contractor training;

2) Designate locations of special sessions deemed appropriate for, and approved by, the Contracting Officer;

3) Evaluate Contractor staff recommended as trainers and direct the Contractor to make changes as deemed necessary by the Contracting Officer;

4) Review and approve or disapprove training courses. In cases where the Department disapproves any course content or method of presentation, the Contractor shall be directed to make modifications as deemed necessary by the Contracting Officer;

5) Approve or disapprove all training plans, updates, and status reports. In cases where the Department disapproves the training plan, updates or status reports, direct the Contractor to make modifications as deemed necessary by the Contracting Officer;

6) Designate Department staff to be responsible for monitoring the Contractor's effectiveness in the training courses and compliance with the training requirements of the contract;

7) Assign Department monitoring staff to meet with the Contractor to discuss training-related issues as needed; and

8) Assign Department Dental Program Consultants to advise, review, and participate in the development of training for Dental Consultants and Clinical Screening Dentists.

20.0 ADMINISTRATIVE SUPPORT OF CONTRACT CHANGES

The Contractor shall assess, control, track and report to the Department on all change instruments. Change instruments shall include Systems Development Notices (SDNs), Dental Operating Instruction Letters (DOILs), Change Orders, Contract Amendments, Contract Waiver Requests (CWRs), Contract Waiver Letters (CWLs), Miscellaneous Change Documents (MCDs), or Problem Statements. The Contractor shall ensure that in addition to the timely implementation of change instruments, all necessary files, codes, and documentation are updated.

20.1 PROBLEM CORRECTION SYSTEM

Pursuant to Exhibit A, Attachment II, Operations Requirements section, the Contractor shall track, respond to, and report on all Problem Statements through the Problem Correction System (PCS), and forward all Problem Statements that require Systems Group (SG) actions to the SG, including but not limited to, erroneous payment corrections, and ensure the timely completion of all PCS deliverables.

20.2 CHANGE ASSESSMENT, TRACKING AND CONTROL

The Contractor's responsibilities shall include, but not be limited to, the following:

1) Meet with the Contracting Officer or his/her designees in committee once a month to review potential DOILs or Change Orders, to clarify policy directives, and discuss potential cost impact. Contractor shall schedule such committee meetings with approval of the Contracting Officer, chair the meeting, record committee meeting minutes, distribute a draft of the minutes for Department approval, and distribute the final approval minutes;

2) Within two (2) State workdays of receipt of a change instrument, acknowledge receipt of the document, forward all SDNs to the SG and maintain centralized tracking and control of these documents to ensure that required time frames are met;

3) Utilize a project status system to report to the Department on the status of each change instrument. Reports shall be produced weekly through the same system as the Systems Group Tracking System and report the following information:

    a) Status of the implementation of the change; e.g., what phase the change is in (use System Development

Notice Phases in Exhibit A, Attachment III, Change Requirements section as a guide);

b) Projected implementation date. This should indicate all adjustments made from the original projected implementation date;

c) All anticipated implementation problems;

d) Ensure that changes to the CD-MMIS are implemented in accordance with the Change Requirements section;

e) Ensure that the Procedure Files, References Files, and CD-MMIS Table Files are updated;

f) Ensure that new codes are added correctly to subsystem files;

g) Ensure that modifications to application programs and manual procedures needed to bring the Contractor into compliance with existing contract responsibilities are implemented;

h) Communicate to the Department and Contractor staff on all changes to CD-MMIS, in accordance with Exhibit A, Attachment II, Operations and Exhibit A, Attachment III, Change Requirements sections;

i) Document all changes implemented by the Contractor through SDNs, DOILs, Change Orders, and other changes including system improvements and emergency fixes, as required in the Change Requirements section;

j) Work closely with the SG to ensure that SG activities are compatible with CD-MMIS operations and provide the best method to perform a required task;

k) Facilitate changes to SG hours; and

l) Ensure that all Contractor CWRs comply with the requirements of the Waiver of Contract Provisions section; track and report on all CWRs; document receipt of CWLs; and ensure that CD-MMIS documentation is updated to reflect any waivers that are granted.